DOCUMENT RESUME

ED 318 191 EC 230 596

AUTHOR Reed, Penny; And Others
TITLE A Model Plan for the Supervision and Evaluation of Therapy Services in Educational Settings. TIES: Therapy in Educational Settings.
INSTITUTION Oregon Health Sciences Univ., Portland. Child Development and Rehabilitation Center.; Oregon State Dept. of Education, Salem. Regional Services for Students with Orthopedic Impairments.
SPONS AGENCY Office of Special Education and Rehabilitative Services (ED), Washington, DC.
PUB DATE Sep 88
GRANT G008630055
NOTE 99p.
AVAILABLE FROM Child Development and Rehabilitation Center Publications, Oregon Health Sciences University, P.O. Box 574, Portland, OR 97207 ($8.00).
PUB TYPE Guides - Non-Classroom Use (055) -- Reference Materials - Directories/Catalogs (132)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Delivery Systems; *Disabilities; Elementary Secondary Education; *Evaluation Methods; Labor Turnover; Models; *Occupational Therapy; *Physical Therapy; *Recruitment; Staff Role; *Supervision
IDENTIFIERS Oregon

ABSTRACT

The manual serves as a model for school districts developing procedures for supervising and evaluating their therapy services. The narrative is addressed to therapists rather than supervisors so that school districts can photocopy or adapt sections of the manual and assemble customized manuals for therapists in their programs. The first chapter, "Therapy Services in Educational Settings," describes a continuum of therapy services, the role of occupational therapy and physical therapy as "related services" under federal legislation, the hallmarks of effective therapy, and the role of supervisory leadership. "Supervision and Evaluation of Therapists Employed by Educational Agencies" provides forms for identifying therapist performance goals and evaluating therapists. Other chapters describe the role of licensed therapist assistants and methods of recruiting and retaining therapists in schools. Appendices include the following: (1) a continuum of student characteristics; (2) a service delivery model; (3) Oregon regulations on teacher evaluations and personnel file content; (4) a model performance appraisal instrument for school physical therapists; (5) information on recruitment and retention of pediatric physical and occupational therapists; (6) directories of educational programs in physical therapy and occupational therapy; and (7) directories of the State Placement Chairmen of the American Physical Therapy Association and the American Occupational Therapy Association. (JDD)

A Model Plan for the Supervision and Evaluation of Therapy Services in Educational Settings

Penny Reed, Judith Hylton,
Nancy Cicirello and Sandra Hall

TIES: Therapy in Educational Settings

A collaborative project conducted by University Affiliated Program of the Child Development and Rehabilitation Center at the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Students with Orthopedic Impairment. Funded by the U.S. Department of Education, Office of Special Education and Rehabilitative Services, grant number G008630055

A MODEL PLAN FOR THE SUPERVISION AND EVALUATION OF THERAPY SERVICES IN EDUCATIONAL SETTINGS

Penny Reed, Judith Hylton
Nancy Cicirello and Sandra Hall

September 1988

In writing this manual we have chosen to avoid awkward word combinations such as (s)he and his/hers, and instead have elected to refer to children as "he," therapists, teachers and aides as "she," and supervisors as "he." We hope the reader will accept this style and find it comfortable, for that is our intent.

We recognize the difference in the names, physical therapist assistant and occupational therapy assistant adopted by their respective professions. In order to arrive at an uncluttered collective term to use when referring to both groups at the same time we flipped a coin. The coin came up heads for the term therapist assistant.

PREFACE

INTRODUCTION

Supervisors in schools who have responsibility for evaluating and supervising the work of physical therapists and occupational therapists working in their program often find themselves untrained to evaluate the parts of the therapists' jobs that actually encompass therapy. On the other hand, therapists, who as a profession are relatively new to the school setting, often experience a strong need for substantive comment on their performance in an environment that is entirely different from the one in which they received their training.

This manual was written to serve as a model for school districts when they are developing procedures for supervising and evaluating their therapy services. The narrative is addressed to therapists rather than to supervisors so that school districts can adapt or directly photocopy sections of the manual and assemble tailor-made manuals for therapists in their programs. Because the manual was developed and field tested in Oregon, it contains many references to resources available in that state. When adapting parts of the manual for a program, references to these resources can be replaced with those that are available locally.

Resources available through sources in Oregon and descriptions of policies followed in Oregon are set off with a bold outline for easy identification.

It is recommended that school districts fully inform every therapist and therapy assistant serving their program about the supervision and evaluation policies and procedures used there. Ideally this information should be given to practitioners in written form, such as this manual or an adaptation of it, so that supervisors and practitioners can share a common understanding of what is expected of them and can refer to a common source when questions arise.

BACKGROUND

Project TIES: Therapy in Educational Settings is a collaborative effort conducted by the University Affiliated Program of the Child Development and Rehabilitation Center at the Oregon Health Sciences University, and the Oregon Department of Education, Regional Services for Students with Orthopedic Impairment. Project TIES was funded by the U S Department of Education, Office of Special Education and Rehabilitative Services, grant number G008630055. The goal of this three year project is to develop training materials for physical therapists and occupational therapists who work in schools with students who have a severe orthopedic impairment.

The topics for these training materials were determined through a series of formal and informal needs assessments by therapists practicing in schools in Oregon. Project staff then grouped the identified needs into topical categories and determined the format that would best convey the content of each topic. Eleven topics were identified, three warranting coverage through both a videotape and a manual.

The training materials were developed primarily for therapists who are new to the unique demands of the school setting or who have had little experience with children who have a severe orthopedic impairment. Other people such as administrators, teachers, aides and parents will find these materials helpful in understanding what therapists do and the rationale behind their efforts to integrate students' therapy programs into the larger context of their educational programs.

In September of 1987, the project completed three manuals:

Considerations for Feeding Children who Have a Neuromuscular Disorder

Selected Articles on Feeding Children who Have a Neuromuscular Disorder

The Role of the Physical Therapist and the Occupational Therapist in the School Setting

Five manuals are scheduled for completion in September of 1988 and three for May of 1989. Those planned for September, 1988, are listed below:

Adapting Equipment, Instruction and Environments in Educational Settings

Developing Functional IEPs through a Collaborative Process

Making Inexpensive Equipment from Tri-wall

Teaching Nontherapists to Do Positioning and Handling in Educational Settings

A Model Plan for the Supervision and Evaluation of Therapy Services in Educational Settings

ACKNOWLEDGEMENTS

Many people contributed their expertise, time and support to this project. We especially want to thank our field readers for their well considered comments and suggestions. Our field readers for this manual were:

Barbara Boucher, PT, OTR
Lynn-Benton Regional Programs, Albany, Oregon

Dan Drechsel, PT
Coos County Educational Service District
Region IV, Coos Bay, Oregon

Tass Morrison
Pupil Services Division Coordinator
Corvallis School District, Corvallis, Oregon

We also thank the physical and occupational therapists in schools throughout Oregon who field tested these materials and offered many valuable suggestions for their improvement. We thank our fine support staff, Renee Hanks, Lyn Leno, and Sharon Pearce, for their efficiency and good humor even while typing revisions of revisions. And we thank the children in Oregon's schools who have taught us how we learn.

We are grateful to Dr. Gerald Smith, Director of Training, University Affiliated Program (UAP) at Oregon Health Sciences University and to Patricia Ellis, Associate Superintendent of Special Education, Oregon Department of Education, whose vision was essential to the inception of this undertaking and whose support vastly contributed to its successful execution.

We are indebted to Allan Oliver, former Art Director of the OHSU Design Center, for his fine work and infinite patience in developing a cover design.

We are thankful for the power of the correction pen wielded by the hand of Ann Gardner, Emeritus Professor at the UAP, whose sharp eye found errors, inconsistencies, and just plain nonsense that our vision had become too fuzzy to see.

Project Director

Judith Hylton, M.S.
Oregon Health Sciences University
Child Development and
Rehabilitation Center
University Affiliated Program
PO Box 574
Portland OR 97207

September 1988

Project Consultants

Penny Reed, Ph.D., Coordinator
Sandra Hall, O.T.R.
Nancy Cicirello, P.T.

Regional Services for Students
with Orthopedic Impairment
c/o Douglas County ESD
1871 NE Stephens Street
Roseburg OR 97470-1493

TABLE OF CONTENTS

CHAPTER 1

THERAPY SERVICES IN EDUCATIONAL SETTINGS

CHAPTER 1
THERAPY SERVICES IN EDUCATIONAL SETTINGS

A CONTINUUM OF THERAPY SERVICES

Under PL 94-142, schools must provide therapy to students who have both a documented handicap that interferes with their ability to benefit from an educational program, and a documented need for therapy. Furthermore, schools are required to have a continuum of therapy services available for students who require them. This continuum ranges from resource (infrequent) consultation through direct (frequent) consultation to direct intervention. The diagram below shows the continuum of therapy services with double arrows to indicate that the students can move either way along the continuum, and that they can receive more intense therapy at some times and less at others, depending on their changing needs.

Resource Monitoring (infrequent consultation) <—> **Consultation (frequent)** <—> **Direct Therapy**

A student's placement on this continuum should be based on characteristics and needs such as age, expected response to treatment, nature of the disabling condition, behavior and intellectual functioning. See Appendices A and B beginning on page 35 for examples of student characteristics that should be considered when determining appropriate levels of therapy.

It is usually accepted that a high level of direct therapy is needed at very young ages to take advantage of the plasticity of a young maturing brain, to prevent structural deformities, and to educate family members in important handling techniques. However, there is no therapy program that can move a child significantly beyond his overall developmental level. Children who are intellectually intact, highly motivated, and whose therapy is accompanied by good follow-up in the home and school are more likely to make changes. But, a 10-year-old child who consistently performs at a 14-month level in all developmental areas will not significantly improve his motor performance through therapy even if the therapy is intensive. This child would be served better if the therapist consulted with others who have responsibility for him, such as classroom staff and adaptive physical education teachers, family members and staff from community leisure and recreational programs. This consultation would result in the therapist's teaching others such things as positioning and handling skills, which can promote the child's participation in functional activities throughout the day.

MOVING BACK AND FORTH ALONG THE CONTINUUM The child whose cognitive level is generally commensurate with his chronological age may shift from direct to consultative therapies later than one who has severe global developmental delay. However, therapy services for all students tend to become consultive as the students become more involved with and challenged by educational, social and vocational activities that take increasing precedent over time spent in direct therapy. Some students may require a temporary shift back to direct therapy to deal with such things as a recent growth spurt, acquisition of new equipment, change in schools, adolescence, or need for vocational planning. Once the need is addressed, periodic consultation may again become the most appropriate mode for delivering service.

Students develop and respond to therapy on both vertical and horizontal planes. Vertical accomplishments are seen in the achievement of developmentally higher skills and horizontal gains occur when the student elaborates and refines existing skills and is able to transfer, or use them in new settings. Learning to walk for the first time is an achievement on a vertical plane. Learning to walk with forearm crutches rather than with a walker is an achievement on a horizontal plane. When a student is making no vertical gains or is making them very slowly he may be unable to benefit from direct therapy and may instead need the opportunity to generalize the skills learned through therapy to new settings such as the classroom, home and the community. When performance improves rapidly and is very dependent upon the intervention, a high level of direct therapy service is indicated. Conversely, when change is minimal, indirect service or consultation to classroom staff may be more effective than direct service.

Learning to walk for the first time

DETERMINING PLACEMENT It is always difficult to determine how much direct therapy time is appropriate. This decision can be made only after the student's needs for therapy have been thoroughly assessed and services have been prioritized according to these needs. When a therapist believes that time spent in direct therapy should be decreased, she can document the impact of this change on the student's progress by employing short periods of decreased direct therapy in an "ABAB" design. For example, if the child has received direct therapy for some time (condition A); the therapist can switch to consultive services only for two to three months, (condition B); she can then reinstate the original level of direct therapy for a similar amount of

time (return to condition A); and again switch to consultative services only (return to condition B). Little or no change in the target skill (eg., heel strike, use of grasp or specific joint range of motion) probably indicates direct therapy is no more effective than consultive therapy. In this case, participating in adaptive physical education or classroom leisure activities may be more beneficial to the student than continued direct therapy.

Sound recommendations for therapy cannot be made on an "all or none" basis. Rather, they should draw upon the full continuum of services as required to match the student's needs. Both therapy intervention and its mode of delivery should be assessed regularly to ensure that they are meeting the child's needs. "More" direct therapy is better therapy only when it produces more positive changes, e.g., increased skills or prevention of deformity, than another mode of service delivery does. Therapy should be planned to meet the needs of each child, not provided automatically because it was on his IEP last year. The IEP team has a responsibility to determine not only if a student needs therapy, but what type, when, how much and for how long.

"A Continuum of Student Characteristics" in Appendix A, and "Service Delivery Model" in Appendix B, are two examples of how the continuum of services can be conceptualized.

OCCUPATIONAL AND PHYSICAL THERAPY AS RELATED SERVICES

Occupational and physical therapy services as part of public school education were initially mandated by Part B of the Education of All Handicapped Children Act of 1975, Public Law 94-142. Each state subsequently developed its own state law to bring local practices into compliance with PL 94-142. The intent of the law is expressed in its statement of purpose: "It is the purpose of this Act to assure that all handicapped children have available to them, within the time periods specified, a free and appropriate public education which emphasizes special education and related services designed to meet their unique needs."
(P.L. 94-142, 1975, Sec. 3, c.)

LEGAL DEFINITIONS - FEDERAL CODE.

1. **Handicapped** - "The term 'handicapped children' means mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children, or children with specific learning disabilities, who by reason thereof require special education and related services." (emphasis supplied) 20 USC 1401(1).

   The implementing regulation, 34 CFR 8, further defines "handicapped children": "As used in this part, the term

'handicapped children' means those children evaluated in accordance with Regs. 300.530-300.534 as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or as having specific learning disabilities, who because of those impairments need special education and related services."

2. **Special Education** - "The term 'special education' means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." (emphasis supplied)

   This specifically designed instruction can take place in a regular classroom but it must be documented in an IEP.

3. **Related Services** - The term 'related services' is defined at 20 USC 1401(17): "The term 'related services' means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes early identification and assessment of handicapping conditions in children." (emphasis supplied)

An awareness of these definitions is crucial to understanding a child's entitlement to physical and occupational therapy under the laws governing special education programs. As the United States Department of Education specifically noted in its comment immediately following the definition of special education found at 34 CFR 300.14:

> Comment. (1) The definition of 'special education' is a particularly important one under these regulations; since a child is not handicapped unless he or she needs special education. (See the definition of 'handicapped children' in section 300.5). The definition of 'related services' (section 300.13) also depends on this definition, since a related service must be necessary for a child to benefit from special education. Therefore, if a child does not need special education, there can be no 'related services', and the child (because not 'handicapped') is not covered under the Act." (emphasis supplied)

Under the law, children are not considered to be handicapped unless they actually need specially designed instruction or are found to have a physical, mental, etc., disability which adversely affects their ability to learn. Supportive services such as physical and occupational therapy are "related services," not specially designed instruction. Federal law specifically provides that "related services"

are to be provided to those children defined as "handicapped" under the law when such related services are required for the child in question to benefit from the child's program of specially designed instruction.

Even when a child is handicapped (because the child needs specially designed instruction), the child does not automatically receive related services. Rather, the child is entitled to receive such related services as are required for the child to benefit from the program of specially designed instruction. Physical and occupational therapy services covered under P.L. 94-142 are only those services which enable the child to benefit from special education.

The term "related services" means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children. (20 USC 1401(17))

If it is determined through assessment/evaluation that the child is eligible for educationally related physical or occupational therapy services, the IEP should note that physical and/or occupational therapy is the related service to be provided. Implementation strategies such as Neurodevelopmental Treatment or sensory integration therapy are not identified as related services and should not be listed as such. The methods of implementation are to be determined by the provider of that service and may be reflected in the goals and objectives of the IEP. (Education Due Process Reporter, 1981)

The IEP goals and objectives for physical and occupational therapy should be directed to the identified educational needs of the student and should be stated in such a way that they reflect that relationship, i.e., how will physical and occupational therapy assist the student to benefit from his special education program. Documentation of the complete process is essential and should be written in a format/language that is compatible with other educational documents.

Those students not identified as having exceptional educational needs, as well as those students identified as having exceptional educational needs but who do not require physical or occupational therapy to benefit from their program of specially designed instruction, are not eligible for physical or occupational therapy.

Some examples of children who are not eligible to receive therapy as a related service are:

1. Students with a temporary disability such as a fractured leg, muscle injury, etc.

2. Students with a disability or a handicapping condition which does not require the provision of specially designed instruction. Examples of disabilities which may or may not constitute such conditions are clumsiness, scoliosis, traumatic injury to nerves/muscles of the hand, mild cerebral palsy, etc.

3. An amputee who is independent in the use of his or her prosthesis.

4. Any child who has reached maximum benefit from the therapy such that direct therapy, monitoring or consultation is no longer needed.

SCHOOLS MAY BILL A THIRD PARTY "Nothing in the Act or the regulations prohibits the use of State, local, Federal, and private sources of support, including insurance proceeds, to pay for services that may be provided to a child....(300.!11 (d)(1)), as long as the parents are not charged." (From FOCUS, A Review of Special Education and the Law, Vol. 2, No. 4, Sept 1982)

HALLMARKS OF EFFECTIVE THERAPY

INDIVIDUALIZATION For therapy to be effective, it must be individualized, tailored to meet the needs of each student in terms of both content and amount of service provided. In order to individualize therapy, therapists must have sufficient time in their schedule to provide direct "hands-on" therapy to those who need it, and time to consult with other school staff regarding the needs of students who require such services

Caseloads must be of a reasonable size if student needs are to be accommodated. Guidelines for determining the size of caseloads are offered in a previous TIES manual, The Role of the Physical Therapist and the Occupational Therapist in the School Setting. The guidelines take into consideration time needed to travel, write reports, participate in team meetings, and assess newly referred students, as well as time needed to provide therapy and consultation.

Caseloads must be of a reasonable size

COMMUNICATION For therapy to be effective, the therapist must communicate with others. She must have opportunity to participate in the exchanges needed by team members to function as a team, not a quasi team (Giangreco, 1986); and to train others to position and handle students properly and to incorporate therapeutically appropriate activities into students' daily routines. If a therapist provides therapy only in isolation, is excluded from IEP meetings and rarely talks with other staff members, she cannot meet students' needs.

MONITORING For therapy to be effective, it must be monitored and evaluated regularly. It is desirable that a district administrator take the responsibility of monitoring the provision of therapy services, and not just "assume" it is being done appropriately.

The following areas should be considered when monitoring therapy services that are provided by the school district:

duration Over what period are the students typically served? Is the duration of service based on student need?

intensity How often are the students served? Does the time vary according to student need? Do some students receive direct "hands on" therapy or are caseloads so large that only consultation is provided to all students regardless of need?

content What major services are provided? Are they directly related to specially designed educational programs?

scope and sequence Is there a defined progression of services?

degree of individualization To what extent are the services tailored to meet the needs of the students?

degree of relevance To what extent does the therapist know the student's overall special education needs and the program set up to meet them? Are therapy goals written in conjunction with other educational goals rather than in isolation on separate pages or as a separate IEP?

opportunity for integrating skills learned in therapy What are the arrangements for the students to practice skills in functional activities throughout the week?

communication Does the classroom staff know how to handle and position the student appropriately? Does classroom staff know what the therapist is doing? Does the therapist know what other staff members are doing with the student?

feedback mechanisms How is information on student progress exchanged? With whom? How often?

flexibility Is there a fixed schedule and process or are variations possible?

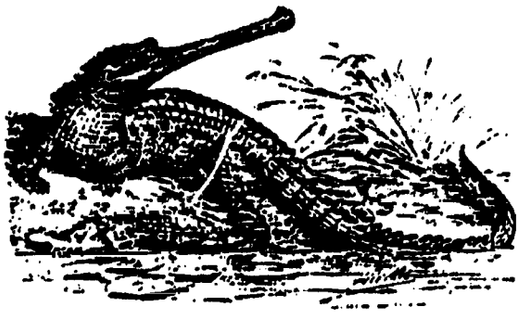
starting point How is the initial placement made? Are therapists involved in decision making?

ending point Do students ever stop receiving therapy? If so, what are the criteria for them to exit from therapy?

monitoring student progress How does therapist know when to move on? What data are collected for decision making? When and how is student progress assessed?

SUPERVISORY LEADERSHIP

Therapists need to be able to rely on their supervisor for guidance and support in carrying out school policies - particularly those related to such confusing areas as appropriately using the many required forms, operating an efficient referral process and implementing an adequate continuum of services.



It's a jungle out there

PAPER JUNGLE The paper jungle that has grown out of the need to document most of the actions taken in special education has created a confusing landscape. New therapists, especially, can become lost in the sheer number of forms they must complete. Because each school district can develop its own set of forms to fulfill the requirements of PL 94-142, therapists who serve students from more than one school district may be unable to sort out these different forms. Some supervisors have supplied therapists, and other staff, with a map to lead them through the jungle. The map is simply a booklet containing completed examples of all the forms used for special education services in the district and a brief, written statement that tells when each form should be used, who is responsible for its completion and where the form should be sent after it is completed.

Supervisors bear a large part of the responsibility for their district's compliance with the laws that govern the delivery of special education services, and for the correct and timely completion of the forms involved in this process. Because it is in the best interest of the Director of Special Education (or other administrator who directly supervises the therapist) that forms be used appropriately, he can be an excellent source of information on how to use them.

REFERRAL SYSTEM In order to be efficient, a referral system must make good use of limited staff time by moving students through the system as quickly as possible; and it must result in documenting a student's eligibility or ineligibility for special education and

related services. Supervisors can have a major influence on the effectiveness of the referral process by building in procedures that minimize the number of unnecessary or inappropriate referrals. For example, Lincoln County School District on the Oregon coast has reduced the number of students referred to their motor team by having the adaptive physical education (APE) specialist screen all children who are referred to the motor team. The APE specialist works closely with both the physical therapist and the occupational therapist and knows when to refer a student on to an appropriate therapist. A copy of Lincoln County's "Request for Motor Team Services" is in Appendix C. You will note the form is written in language readily understandable by teachers and APE specialists, not in the technical terms of a therapist.

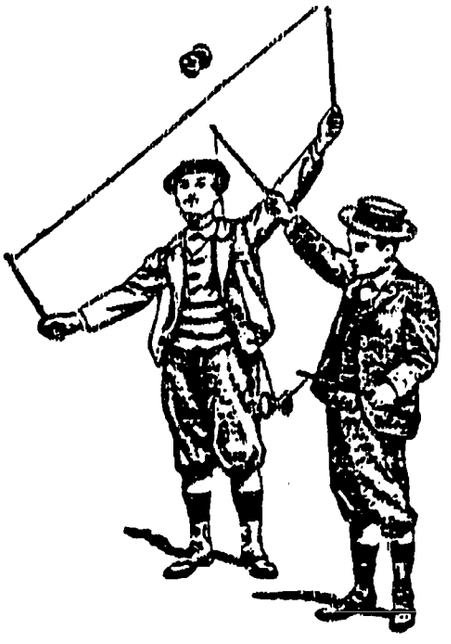
CONTINUUM OF SERVICES The concept of a continuum of therapy services has caused, among other things, a continuum of conflict and confusion. Many people, including professionals in schools and particularly parents, have interpreted a change from direct therapy to indirect therapy as taking needed services away from a student. They often do not recognize that such a change can be a mark of student progress. A change in a student's therapy services can be made smoother if both the supervisor and the therapist can speak articulately on the subject and if they both recognize the sources of resistance presented by parents and by other professionals. Some of the most common issues are outlined below.

The child has made real, perhaps even significant gains while receiving direct therapy. He now needs time to practice and integrate his newly acquired skills in his every day activities. Continued direct therapy at this time may be contraindicated and may even constitute a step backward because it will take time away from the independent use of skills in a more normal routine.

The child has received direct services for a limited period of time so the therapist could develop successful strategies for working with him. Now that these strategies have been developed, the therapist can teach them to other people - therapy assistants, teachers and parents who can use them throughout the student's day. At this point, the most valuable service the therapist can give is to monitor the student's progresss and the work of the nontherapist.

The child no longer needs direct service in order to continue his rate of progress. Whether his progress has plateaued, or continues even slowly, continued direct therapy will not accelerate his progress.

The therapist is an expert in the delivery of therapy services and the administrator is an expert in developing and interpreting policies. Together they can form a natural alliance for promoting the delivery of appropriate services to students who need them and for helping other concerned persons such as parents and professionals work together on behalf of these students.



Together they form a natural alliance

PROVIDING ADEQUATE LIABILITY COVERAGE

The local school district, education service district or regional program should provide liability coverage for the therapists providing school therapy. Two major companies which offer liability coverage to educational agencies for therapy services:

McGinnis & Associates, Inc.
332 South Michigan Avenue
PO Box 94250
Chicago IL 60604

St. Paul Insurance Company
contact local agents

CHAPTER 2

SUPERVISION AND EVALUATION OF PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS EMPLOYED BY EDUCATIONAL AGENCIES

CHAPTER 2
SUPERVISION AND EVALUATION OF PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS EMPLOYED BY EDUCATIONAL AGENCIES

SUPERVISION OF THERAPISTS

If you are an employee of a school district, education service district, or regional program in Oregon, you will receive formal supervision as required by ORS 342.850. This statute governs the supervision of teachers in the schools. (See Appendix D for a reprint of the statute.) In most cases, you will belong to the same bargaining unit as the teachers and will, therefore, be covered by the policies that apply to them. This statute requires each school district board to develop an evaluation process that includes job descriptions and performance standards.

The process also must include:

an interview before the evaluation to develop performance goals

an evaluation based on written criteria related to the performance goals

an interview following the evaluation in which the results of your evaluation are discussed with you

Each district develops its own forms to fit its individual policy

Although specific forms are used for each of these steps, each district develops its own forms to fit its individual policy. A "Sample Form: Individual Performance Goals" is on page 13.

Ask your administrator for your district's written policy. It should include all of the required steps. School policy is often included in a district's personnel handbook.

Sample form: INDIVIDUAL PERFORMANCE GOALS

For_____ Position_____

We have read and discussed the following goals and how they will be evaluated. These goals are established for the _____ school year and will appear in the final evaluation report for the year designated.

GOALS:

Employee's Signature	Supervisor's Signature	Date

EVALUATION AND COMMENTS:

This is to certify we have discussed the achievement of the above goals. (Employee's comments, if any, are attached.)

Employee's Signature	Supervisor's Signature	Date

(Developed by Douglas County ESD, Roseburg, Oregon 97470)

PERFORMANCE GOALS You will meet with your supervisor to discuss and agree on performance goals for you. These usually must be developed by October 15 of each school year. Your performance goals can relate to any of the items in your job description or performance standards. Examples of some goals typically developed by therapists are shown below.

1. Learn to use two new functional tests to assess students' need for therapy.

2. Develop or organize a set of handouts to help parents implement motor programs.

3. Develop a data collection system for motor programs which are implemented throughout the school day as part of functional skill sequences.

4. Learn to use Appleworks to write therapy reports more quickly.

You may have other performance goals not directly related to specific items in your job description:

5. Develop an in-service presentation to help school staff understand the role of the physical and occupational therapist in the school.

6. Investigate the use of licensed physical therapist assistants (LPTAs) in the school by reading articles or manuals and visiting one or more programs where LPTAs are being used.

7. Increase knowledge of augmentative communication equipment by reading one book and attending one conference or workshop during the year.

EVALUATION Within a few weeks after you develop your performance goals, you can expect your supervisor to formally observe you. Often the first observation of new staff must be completed sometime in December.

Discuss the problem with your supervisor

Although the forms used in this observation vary from district to district, their common purpose is to document that you are doing your job. In many districts the form, originally developed for teachers, may contain items which do not apply to you. If this happens, you can discuss the problem with your supervisor and suggest that a supplemental sheet containing items which better reflect the components of your job be attached to the

school form. A form that was designed specifically to evaluate the work of physical therapists and occupational therapists who work in the schools contains a selection of these items. The form, "Sample Form: Physical and Occupational Therapy Personnel, Observation and Supervision Summary," appears on pages 16-18. It can be adapted by a school district for use as is, or the therapist can choose items from it for inclusion on a sheet that supplements her district's evaluation form.

In other districts, the actual observation sheet is a blank form on which you state your objectives for the student(s) with whom you will be working during the observation period. The supervisor's task is to determine if you are accomplishing those objectives and to give you feedback about your performance.

Sample form: PHYSICAL AND OCCUPATIONAL THERAPY PERSONNEL OBSERVATION AND SUPERVISION SUMMARY

School District
Address

Name:_____ Date:_____ Observed by:_____

School Program:_____ Time & Length of Visit:_____

Status: temporary probationary 1 2 3 permanent

		meets or exceeds acceptable standards yes	no	n/a	comments
1.0	STUDENT ASSESSMENT/EVALUATION				
1.1	Establishes and maintains a referral process.				
1.2	Selects appropriate evaluation instruments and procedures.*				
1.3	Assesses student performance using both formal and informal assessment techniques.				
1.4	Interprets evaluation/assessment data accurately and appropriately.*				
1.5	Collects and maintains data on student performance and reports progress in relation to IEP.				
2.0	PREPARATION, PLANNING, AND ORGANIZATION				
2.1	Coordinates therapy intervention with school personnel and outside agencies.				
2.2	Develops IEP goals in collaboration with parents and other school staff.				
2.3	Writes objectives as needed for all goals which require contributions from the therapist.				
2.4	Assembles materials and equipment and has them ready for use when needed.				
2.5	Prioritizes caseload according to student need and time available.				
2.6	Completes required paperwork on time and in an acceptable manner.				
3.0	INTERVENTION/SERVICE DELIVERY				
3.1	Provides direct, indirect, and consultation services appropriately.*				
3.2	Utilizes intervention techniques which positively impact progress on IEP goals and objectives.*				
3.3	Selects and adapts equipment appropriately to facilitate student's acquisition of skills.				
3.4	Selects activities and materials appropriate to student's age and instructional level.				

		meets or exceeds acceptable standards yes	no	n/a	comments
3.5	Instructs, supervises and monitors school personnel in the areas of therapeutic concern; e.g., positioning, lifting, toileting, feeding.*	____	____	____	
3.6	During direct intervention with students, provides appropriate cues, maintains attention and consequates behavior appropriately.	____	____	____	
3.7	During direct intervention with student, utilizes positioning and handling techniques which maximize student's potential for functioning.	____	____	____	
3.8	Discontinues or modifies intervention programs appropriately.	____	____	____	
4.0	PROGRAM MANAGEMENT				
4.1	Implements policies and directives of the administration.	____	____	____	
4.2	Establishes priorities and schedules for therapy services with appropriate school personnel.	____	____	____	
4.3	Maintains student files in a complete and organized manner.	____	____	____	
4.4	Develops and adheres to a written schedule and manages time effectively.	____	____	____	
4.5	Regularly evaluates needs and effectiveness of the therapy program and makes revisions as indicated.	____	____	____	
4.6	Assists in budget planning and recruitment of therapy staff as requested.	____	____	____	
4.7	Trains and supervises other therapy staff when assigned.	____	____	____	
4.8	Maintains inventories of equipment, materials and supplies.	____	____	____	
4.9	Establishes and updates policies, procedures and forms according to state and federal laws and regulations.	____	____	____	
5.0	COMMUNICATION				
5.1	Uses a tactful approach with staff, students and parents.	____	____	____	
5.2	Communicates effectively with outside agencies as needed for each student.	____	____	____	
5.3	Maintains confidentiality regarding students and other professionals.	____	____	____	

		meets or exceeds acceptable standards yes	no	n/a	comments
5.4	Collaborates effectively with school staff and parents to implement programs in functional contexts and LRE.	____	____	____	
5.5	Represents the school district in a positive manner.	____	____	____	
6.0	PROFESSIONAL DEVELOPMENT				
6.1	Adheres to ethical standards of his/her therapy profession.	____	____	____	
6.2	Accepts constructive criticism and implements suggestions.	____	____	____	
6.3	Participates actively at in-services and staff meetings.	____	____	____	
6.4	Participates in professional growth activities and continuing educational opportunities.	____	____	____	

SUMMARY/COMMENTS:_____

_____

_____

_____

_____

The information contained herein has been read and discussed by those whose signatures appear below:

_____ _____

Supervisor's Signature and Date Therapist's Signature and Date

Therapist's Comments:_____

_____

_____

* May require the input of a licensed therapist. The non-therapist supervisor may want to may want to utilize the consultation of a therapist for these areas, both to adequately evaluate the therapist and to provide the therapist with appropriate feedback.

BENEFITS OF THE SUPERVISION AND EVALUATION PROCESS

He can learn what a therapist does with a student

A supervision and evaluation program that is well conceived and well executed can open a mutually beneficial exchange between the therapist and the supervisor. The therapist can learn how better to tailor her activities to enhance the school program. She can ask specific questions about the performance standards used to evaluate her work, and she may learn areas in which she may need to develop additional expertise. The supervisor can increase his understanding of therapy as a discipline and the many ways it can serve the program. He can learn more exactly what the therapist does with a student, and even why. The purpose of the supervision and evaluation process is to benefit both the supervisor and the employee. (Linsey, 1986). A reprint of her article, "A Model Performance Appraisal Instrument for School Physical Therapists," appears in Appendix E. Some of the benefits the supervisor and the therapist can realize as a result of the supervision process are listed below.

benefits the supervisor receives
- information about the therapist's activities and schedule
- information about the quality of the therapy program
- a basis for making objective decisions about personnel and programs

benefits the therapist receives
- opportunity for recognition and support
- opportunity to improve performance
- enhanced satisfaction through feedback
- facilitation of achievement of professional goals
- encouragement of professional growth and development

mutual benefit to the supervisor and the employee
- promotion of a partnership between the two

SUPERVISION BY A NONTHERAPIST SUPERVISOR Typically, school therapists, except those in very large districts are supervised by a nontherapist. The administrator assigned to do this is usually a principal or a special education supervisor who has no training in therapy. Although supervisors can be expected to be skillful in areas such as instruction, communication, organization and personnel management, they are unlikely to have the same technical skills for

which they hired the therapist. Consequently, the nontherapist supervisor is well qualified to evaluate many aspects of the therapist's performance in areas such as organization, communication, parent and community contact and the maintenance of useful data on student performance, as well as some aspects regarding the provision of adapted equipment and the implementation of programs. However, a nontherapist is unqualified to determine if the treatment techniques employed by the therapist are appropriate and are correctly executed. Listed below are areas a nontherapist supervisor is qualified to evaluate and those that require the particular expertise of a therapist.

AREAS A NONTHERAPIST SUPERVISOR IS QUALIFIED TO EVALUATE	**AREAS THAT SHOULD BE EVALUATED BY A LICENSED THERAPIST**
<u>Student Assessment</u>	
- completion of student assessments - collection of data on student performance	- selection of appropriate assessment tools and procedures - interpretation of assessment data
<u>Intervention and Service Delivery</u>	
- provision of therapy interventions - use of a collaborative process when writing IEP goals - writing IEP objectives - assembling of materials and equipment - prioritizing of caseloads - completion of paperwork	- use of appropriate interventions - appropriate selection and adaptation of equipment - use of appropriate positioning and handling techniques - appropriate modification of interventions
<u>Program Management</u>	
- training of other staff - management of student behavior - implementation of administrative policies - establishment of priorities and schedules - maintenance of student files - development of and adherence to a schedule	
<u>Communication</u>	
- use of effective and appropriate communication - maintenance of confidentiality	

Professional Development

- acceptance of criticism
- participation in staff meetings
- participation in professional growth institutes
- adherence to the ethical standards of the profession

USING A CONSULTANT TO ASSESS PERFORMANCE One way to ensure that therapists in the school receive an adequate evaluation is to have the nontherapist administrator assess the areas that fall within his realm of expertise, and to use a therapist consultant to assess the areas that require the expertise of a licensed therapist.

ORS 342.850 states that "nothing in this subsection is intended to prohibit a district from consulting with any other individuals." This means that school districts can arrange for therapists to serve as consultants as part of the evaluation process. The licensed therapist can do the following:

determine if the therapist has appropriately assessed all areas of a given child's orthopedic difficulties

determine if the treatment provided for a child is appropriate

suggest alternative assessment and treatment techniques

provide feedback to the therapist concerning the appropriateness of her assessment and treatment

demonstrate appropriate assessment and treatment techniques

determine if the amount and type of service (i.e., direct treatment, regular consultation, minimal consultation) for a given child is appropriate

determine if the therapist is providing appropriate and adequate information to educators, parents and the medical community

SOURCES OF CONSULTANTS Using a consultant need not entail large expenditures of money. Four potential sources of consultation are:

A large expenditure of money

intra program — If the district has more than one PT and more than one OT, it can arrange for the therapists to observe and consult with each other.

inter program — The district can arrange with another district to trade consultative services between therapists.

contract — The school district can contract with another agency or institution and pay for its therapist to consult for it. Sources of therapists for this purpose are other school districts, educational service districts, regional programs and clinical facilities such a Crippled Children's Division and Shriner's Hospital. Note: When contracting for a therapist outside an education system, it is critical that the school district ensure that she is well versed in therapy as practiced in an educational setting. Some clinical therapists may lack this expertise even though they are highly skilled in pediatric therapy.

state consultants — In Oregon, the district can use the State OI Technical Assistance Team (as long as its positions are funded) for this type of consultation.

When enlisting a consultant to assess a therapist's performance and to give her feedback, the supervisor must specify the areas he wants her to address and he must still complete all of the required observations and forms. He must also attach the consultant's written report to the completed district forms.

One caution!

One caution! If a supervisor wants to use input from a consultant to document suspected inadequacies in a therapist's performance, he must choose a consultant who comes from an outside source, and who is not a member of the same bargaining unit as the therapist. The supervisor should explicitly tell the consultant what his concerns are so she can address them, and she should give her feedback directly to the supervisor rather than to the therapist.

A "Sample Form: Therapist-Therapist Observations" for therapists to use when observing another therapist is on page 23.

Sample form: THERAPIST - THERAPIST OBSERVATIONS

Name:	**Therapist Observing:**
School:	**Date:**
Time Observed:	**Students:**
Pre & Post Conference Time:	

A. Organization	**Comments:**
__ 1. Assessment completed	
__ 2. IEP written	
__ 3. Prescription for treatment on file	
__ 4. Therapist follows daily schedule	

B. Implementation	**Comments:**
__ 1. Activity appropriate to short and long term objectives on IEP	
__ 2. Materials/equipment assembled and ready for use	
__ 3. Activity appropriate for student's developmental level	
__ 4. Activity reflects functional needs of student	

C. Treatment Technique	**Comments:**
__ 1. Positioning and handling appropriate for student	
__ 2. Facilitation and inhibition techniques appropriately used	
__ 3. Treatment technique positively impacts progress to IEP goal	

D. Adapted Equipment **Comments:**

__ 1. Adapted equipment facilitates student's needs

__ 2. Modifications to existing equipment:
- __ are being considered
- __ are planned
- __ depend upon funding which is being pursued
- __ are being constructed by school personnel

E. Parent & Community Contact **Comments:**

__ 1. Contact with outside agencies is maintained for this student, e.g., CCD, MDA

__ 2. Routine contact is maintained with parents

F. Student Data **Comments:**

__ 1. Student responses recorded

__ 2. Data are up to date

__ 3. Programmatic changes made as necessary

__ 4. Regular contact is maintained with student's physician
- __ Annual Rx for treatment
- __ Annual therapy summaries

G. Other **Comments:**

Signature of Observer _____ **Title** _____

From: School District 4J, Educational Support Services, Eugene, Oregon 97402

PREPARING TO BE EVALUATED

Evaluation of a therapist's performance in the school setting is not a one way process in which the evaluator does something to the person who is evaluated. Rather, it is an interactive exchange in which two professionals play complementary roles. However, administrators and supervisors have the advantage of having completed certain university course work that qualifies them to conduct personnel evaluations; but we know of no courses offered to other professionals in the school that will prepare them to participate actively in a formal evaluation process.

The following tips, used in the private sector and adapted for use in the school setting may be useful to you.

PREPARATION Learn what performance standards will be used to evaluate your performance. Get them in writing, preferably in a copy of the same form that will be used during your evaluation.

Identify for yourself ways in which you have met the performance standards. Write down examples of your behavior that support your own assessment, or at least say them to yourself so they will be readily available to you during your assessment.

If you rated yourself as not meeting some of the performance standards, try to identify why. Consider the following:

- inadequate skill or knowledge (e.g., inadequate training, experience or opportunity to practice)

- inadequate motivation or interest on your part (e.g., inability to accept the school's philosophy of treatment or disinterest in helping the school achieve its goals)

- inadequate administrative support (e.g., lack of an efficient referral system, unclear procedures for handling paperwork, or lack of administrative support or leadership in making decisions)

- inadequate resources (e.g., lack of appropriate materials, equipment, space, or time to manage the caseload assigned to you)

An exchange between two professionals

DURING THE OBSERVATION Remember, this is an exchange between two professionals and conduct yourself accordingly. Welcome the supervisor

to your working environment and offer him a chair. You might suggest a spot where he will be comfortable and able to see your work without interfering with it.

If the supervisor does not tell you, ask him how he plans to proceed. Ask if there is anything in particular he wants to see or talk about and tell him about any items on your own agenda.

Explain what you are doing during the observation if you can without interfering with your work. Emphasize how your services contribute to promoting the student's participation in the educational program.

Listen to your supervisor's feedback

DURING THE FEEDBACK Listen to the supervisor's feedback. If you believe he missed some positive points, mention and describe them specifically. He may have had no opportunity to see you doing some of your finest work. Do not argue your point (and yourself) into the ground. If you believe you have been assessed significantly lower than your performance warrants, ask for information about the specific incidents that have led to this view of your work. You may also want to describe what you have done during the period of time that is being evaluated now.

Remember, some supervisors use a private scale when assigning points. Some consider a perfect score a reflection of work that is absolutely flawless and therefore, unobtainable. Others believe people should be marked down on their weaker points (even if they are more than adequate) so as to contrast them with stronger performance. And still others believe that unless an employee receives some lower scores she will not strive for improvement. Do not try to change the administrator's mind. You cannot argue productively against a private scale, but you can ask for specific advice about, and support for improving your own performance.

Develop goals with the supervisor to improve your performance. If you need some support to accomplish them, such as additional training, resources, or administrative cooperation, ask the supervisor for assistance in getting it. If necessary, make an appointment for an update on your progress.

CLOSURE Thank the supervisor for taking the time and interest to give you feedback. Point out what was especially helpful to you. Summarize your newly developed goals and mention any way the supervisor has agreed to help you reach them.

MONITORING OF CONTRACTED THERAPY

Some therapists contract with a district to provide therapy and are not employed by the district. As a contractor, a therapist is not required to develop performance goals or to participate in a mandatory evaluation process. However, it is desirable that the contract include arrangements for a district administrator to provide regular monitoring of the services provided.

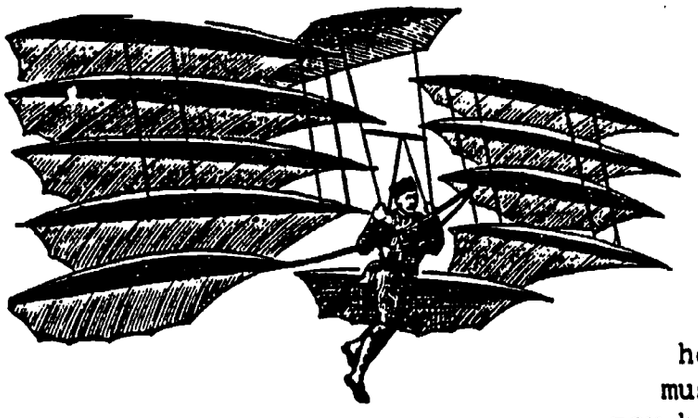
The contract may be written for a specific number of hours or for specific tasks. For example, a contract which identifies the services to be provided may contain items such as:

1. Complete evaluations on all students who have been referred, including written reports, by November 25, 1988.

2. Train classroom staff to carry out therapy recommendations for positioning and handling.

The details of contracts will vary. If a district is contracting for a very limited amount of time, it must prioritize the services it wants to purchase and the students it wants served. If the district is contracting for full service from a therapist, the therapist should have the flexibility to prioritize and schedule her own time.

In a contracting situation, the district may not provide liability coverage for the therapist. The therapist should insure that she is covered with appropriate liability and malpractice insurance. If the therapist works for a clinic or hospital, she may be covered by its group policy. If she is in private practice, she will need to obtain her own insurance.



Launching a private practice can be complicated. In addition to carrying her own insurance, a therapist must obtain a business license, pay her own premiums for workmen's compensation, advertise and obtain space for her business. The American Physical Therapy Association, North Fairfax Street, Alexandrea, Virginia 22314, has a Private Practice Section which provides excellent information on establishing a private practice.

CHAPTER 3

LICENSED THERAPIST ASSISTANTS

CHAPTER 3
LICENSED THERAPIST ASSISTANTS

ROLE OF LICENSED THERAPIST ASSISTANTS

Licensed assistants can be trained by a therapist to provide therapy under her direction to an entire caseload. A teacher or classroom assistant, on the other hand, can be instructed by the therapist to perform only specified activities with only specified children. The licensed therapist assistant is expected to generalize her knowledge about therapy from one child to another, and to act on decisions she makes independently of the therapist, but which are monitored by the therapist. Classroom teachers and classroom assistants lack the training to make these types of decisions.

Qualifications

> COTAs and LPTAs must have graduated from a program that qualifies them for an Oregon license as an occupational therapy or physical therapist assistant. Assistants, by nature of their training, are expected to be knowledgeable about handicapping conditions and the application of recommended treatment techniques. They are expected to understand the principles that govern normal development and learning. (Hylton, Reed, Hall, and Cicirello, 1987)

Although licensed physical therapist assistants (LPTA) and certified occupational therapy assistants (COTA) can be a valuable asset to any therapy program, their use in Oregon schools has been limited primarily to the Portland Metropolitan area. The main reason for the scant use of licenced therapy assistants in other parts of the state is probably due to a shortage of them. Currently Mt. Hood Community College in Gresham, near Portland, provides the only training program for licensed therapy assistants in the State.

SUPERVISION OF LICENSED THERAPIST ASSISTANT

If licensed assistants (LPTA or COTA) are employed by the school district, you as a therapist may be expected to provide their clinical supervision.

> The therapist-licensed therapist relationship in the school and in the clinical setting is similar. The therapist delegates work, including therapy activities she deems appropriate to the assistant, and supervises this work. Licensed assistants help the therapist assess student's needs and help plan Individual Education Programs; and they implement therapy programs that have been developed under the direction of their supervising therapist.
>
> All therapy given by COTAs and LPTAs must be supervised by their respective supervising therapist. While the therapist need not observe all of the assistant's activities, she must regularly monitor these activities through at least monthly contacts. The therapist and licensed assistant must develop a plan to follow if the student's status changes rapidly or in an unexpected manner, and the therapist should, of course, be available to the licensed assistant to answer questions and to help with problem solving. The therapist reevaluates the student at least yearly or more often if needed. (Hylton, et al., 1987)

Keeping a record of the contacts made for supervision may be helpful. A simple log like the one illustrated below shows one way to record contacts.

LOG OF THERAPIST-THERAPY ASSISTANT CONTACTS		
Date	Place	Topics Discussed

ASSIGNING RESPONSIBILITIES TO LICENSED THERAPIST ASSISTANTS

> Of course, therapists must use good judgement when assigning responsibilities to a licensed assistant. Therapists should assign only those responsibilities they judge as appropriate and safe for the child and within the ability of the assistant to perform. (Hylton, et al., 1987)

A comparison of the performance responsibilities for therapists, licensed therapist assistants and classroom assistants follows.

THERAPISTS	LICENSED THERAPIST ASSISTANTS	CLASSROOM ASSISTANTS
Assess student's level of functioning and need for therapy	Assist in the assessment of student's level of functioning and need for therapy.	Provide information to the therapist about the student's functioning based on observation.
Develop an Individual Educational Program (IEP) for student in the area of physical or occupational therapy and participate in IEP meetings with parents.	Assist in the development of an Individual Educational Program (IEP) for student in the area of physical or occupational therapy and participate in IEP meetings with parents at the direction of the therapist.	Do not participate.
Develop and implement therapy programs to meet IEP goals.	Implement therapy programs for many students to meet IEP goals and give feedback to therapist on implementation of program.	Implement specific motor programs or activities that are related to therapy and are specifically recommended by therapist or therapy assistant for a particular student.

THERAPISTS	LICENSED THERAPIST ASSISTANTS	CLASSROOM ASSISTANTS
Design motor programs and teach parents, teachers, classroom assistant and other appropriate personnel to implement them.	Teach parents, teachers, classroom assistant and other appropriate personnel to implement motor programs as prescribed by the therapist.	Do not train others.
Collect and record data on therapy programs.	Same	Same
Monitor and evaluate therapy programs using observation, data and/or pre-post testing.	Monitor therapy programs using observation, data and/or pre-post testing.	Report student's performance on motor programs to therapist or therapy assistant.
Manage student behavior during therapy.	Same	Same
Work cooperatively and communicate appropriately with teaching and support staff.	Same	Same
Develop and adhere to a daily schedule.	Same	As directed by teacher
Order appropriate materials and equipment; use and maintain them.	Same	Use and maintain selected equipment as directed.
Monitor and report student performance and progress.	Same	Same
Attend staff meetings and serve on committees.	Same	As directed by teacher

THERAPISTS	LICENSED THERAPIST ASSISTANTS	CLASSROOM ASSISTANTS
Complete required reports, IEP's and other forms promptly and in an acceptable manner.	Same	As directed by teacher
Negotiate professional growth goals with supervisor.	Same	Same
Perform such other educationally related duties as assigned by the supervisor.	Same	Same

REQUIREMENTS FOR SUPERVISING LICENSED THERAPIST ASSISTANTS

The supervision of the licensed therapist assistant in the school setting is a responsibility shared by the special education administrator and the supervising therapist. The special education administrator (special education director, supervisor or building principal) is responsible for the personnel supervision. He must meet with the therapist assistant to establish performance goals, set up and complete the required observation, evaluate her performance and give her feedback about that performance. Within that process, the therapist who is providing the clinical supervision may be asked to give a written statement about the individual's skills in implementing therapy programs, or any other information the nontherapist administrator could not be expected to judge. This written statement can then be attached to and incorporated in the formal evaluation document.

CHAPTER 4

RECRUITING AND RETAINING THERAPISTS IN SCHOOLS

CHAPTER 4
RECRUITING AND RETAINING THERAPISTS IN SCHOOLS

INFORMATION FOR RECRUITING

If you are asked to help recruit therapists for your school district, the following considerations may prove useful to you, or may be something you will want to share with your administrator. Effgen (1985) points out that schools can compete with hospitals if they emphasize what they have to offer. See Appendix F for a reprint of her article "Recruitment and Retention of Pediatric Physical and Occupational Therapists."

LOCATION - Oregon is a desirable location. Rural areas in Oregon find it more difficult to recruit therapists than metropolitan areas do.

Emphasize what your area has to offer: sports, scenery, peace and quiet!

SALARY - Salary is always important. Pediatric therapists in schools may earn less than their counterparts in hospitals. However, a school district's salary scale typically has several more "steps" than a hospital's does; and therapists who work in the schools may be able to work up to higher salaries than they could in hospitals. Point out other advantages (summer vacations, Christmas holiday, shorter workdays, no weekends).

Emphasize shorter work days and shorter work years.

Create full-time positions through interagency agreement whenever possible. It is more effective and less expensive than contracting.

BENEFITS - Benefits can be as important as salary to some therapists. Check with your district so you can explain medical insurance, dental insurance and other benefits your district offers.

Employees of Oregon public schools are part of the Public Employees Retirement system (PERS), an excellent retirement program. Many districts pay the employees' contribution to PERS as well as the district's.

CONTINUING EDUCATION - Continuing education is the major avenue of achieving the skills necessary to be a competent pediatric therapist. Providing opportunities for continuing education is a significant factor in recruiting and retaining therapists.

Emphasize the continuing education opportunities available and the support your district will provide in terms of release time, registration fees and travel expenses.

CLIENT POPULATION - Pediatric therapists want to work with children, generally the younger the better. They usually prefer a cross section of disability levels and diagnoses. Always working with those having severe or profound handicaps or who are terminally ill can lead to more rapid therapist attrition.

Emphasize the diversity of caseloads; arrange for diversity through cooperative efforts and interagency agreements.

SUPERVISION - Therapists should be supervised by therapists. If this is not possible, arrange for peer review consultation from skilled pediatric therapists.

Emphasize the availability of technical assistance and consultation. Arrange for this form of support through contracting, if necessary.

Use state consultants/specialists for input.

Develop agreements with other school districts, ESD's or Regional Programs to exchange or pay for consultations.

ACCESS TO OTHER THERAPISTS - Studies indicate that access to other therapists is critical. (Effgen, 1985) It allows for exchange of information, tutoring, monitoring, and in general encourages professional development.

Emphasize access to pediatric interest groups and support the therapist's participation.

Use state consultants/specialists for technical assistance.

Encourage and support site visits to other schools.

SPACE AND EQUIPMENT - Both are important in attracting therapists to positions. If they have to work in the supply room, they will not feel very valued.

Emphasize the value you place on therapists by providing appropriate space and equipment for their work.

ADVERTISING - When recruiting therapists, it is helpful to advertise.

Addresses of professional publications such as PT Forum, OT Forum and The Association of Serverely Handicapped (TASH) Newsletter are in Appendix F.

Addresses of PT and OT schools are in Appendices G and H, respectively.

Addresses of State Placement Chairmen for the American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) are in Appendices I and J, respectively.

It pays to advertise

It also may be very effective to advertise in local and regional newspapers. You never know when a therapist will be looking for work in your area.

The Oregonian is an especially effective avenue for advertising positions in Oregon because it is distributed statewide. The Wednesday and Sunday editions are regarded as important ones for recruiting.

Whenever possible, recruit in person at national or state AOTA or APTA meetings. You should also send position announcements to all universities with training programs.

These factors related to successful recruiting also influence how long a therapist will remain in a position. Let administrators in your district know how successful they have been in providing these critical components.

SERVING AS AN AFFILIATION SITE

A good way to attract therapists to a particular district or agency is to arrange for therapy students to do their pediatric affiliation or internship in your school. Universities often send their students out of state to do affiliations, so you need not be limited to in-state schools.

One of the major requirements to be an affiliation site is to have at least two therapists of the same discipline on staff. This will insure that if one therapist becomes ill or resigns, the student therapist will still have a supervising therapist for her affiliation. Each staff therapist must have one year's experience.

Programs in Oregon seeking affiliation sites are listed below.

Pacific University in Forest Grove places both OT and PT students in school affiliations. Contact Darlene Wingfield, PT Department or Lillian Crawford, OT Department, (503) 357-6151.

Mt. Hood Community college places both COTA and LPTA students. Contact Lynn Lippert, PT Department or Chris Heincinski, OT Department, (503) 667-7180.

To arrange to be an affiliation site for an out of state college, contact any of the schools listed in Appendices E and F. The school will send you the requirements of affiliation sites for their program.

NETWORKING

It is important for the therapist to find sources of contact with other therapists.

Physical and occupational therapists who work in the school setting often are isolated professionally. Most small school districts and educational service districts have only one PT and one OT on staff. Districts contracting for therapy services may purchase only a small amount of time for a therapist to be in the school. Either of these situations can leave the therapist with no access to professional peers, no source of feedback and little or no support. In such circumstances, it is important for the therapist to find sources of contact with other therapists. There are many state and county organizations but, if no group meets in your part of the state, you may want to initiate one.

Potential sources of professional contact in Oregon are listed below.

The Oregon PT Association	The Oregon OT Association
_____	_____
_____	_____
_____	_____
_____	_____

The two Pediatric Special Interest groups in Oregon meet several times a year and include both PTs and OTs. One group is in the Portland metropolitan area, the other is in the Southern Oregon, Medford-Grants Pass-Roseburg area.

Pediatric Special Interest Group
c/o Louise Sasso
3101 SW Sam Jackson Road
Portland OR 97201
Phone: 241-5090

Pediatric Special Interest Group
c/o Marilyn Gradwell
PO Box 553
Jacksonville OR 97530
Phone: 895-7034

APPENDICES

APPENDIX A
A CONTINUUM OF STUDENT CHARACTERISTICS:
A Guide to Placement for Therapy Services
A WORKING DRAFT

PURPOSE This guide was developed to assist in placing students along the continuum of services for therapy and to aid therapists in prioritizing services for students on their caseload. It contains categories of student characteristics arranged in four columns marked a, b, c and d. The columns represent a continuum of student characteristics ranging from a low need for therapy (column a) to a high need for therapy (column d).

SCORING To use the guide, determine which characteristics best describe a student and circle the number in the appropriate column on the worksheet. Then enter the score for each characteristic in the score box on the worksheet and total the scores. Enter the total score in the total score box. Use the comments section to record any pertinent information that is not captured by the scoring and that could influence decisions about placing the student.

APPLICATION No cut-off scores have been established for the guide. In general, students who are best represented by the a descriptor should be placed near the Resource end of the continuum of services and those best represented by the d descriptor should be placed near the Direct Intervention end of the continuum. Districts can establish their own criteria for placement along the continuum of services and they can rank the total scores for groups of students to prioritize the student's need for therapy services.

Student's Name _____ Date_____ Completed By_____

Characteristics	Need For Therapy Low a b c High d	Score	Comments
1. AGE	0 3 7 10		
2. OBSERVED RATE OF CHANGE	0 3 7 10		
3. EFFECTS OF THERAPUTIC INTERVENTION	0 3 7 10		
4. EXPECTED RESPONSE TO TREATMENT	0 3 7 10		
5. NATURE OF CONDITION	0 3 7 10		
6. POSSIBILITY OF NEEDS BEING MET BY OTHER PEOPLE	0 3 7 10		
7. IMMEDIACY OF NEED	0 3 7 10		
8. THERAPY IN RELATION TO OTHER TIME NEEDS OF STUDENT	0 3 7 10		
9. STUDENT'S BEHAVIOR	0 3 7 10		
10. INTELLECTUAL FUNCTIONING file review: date and source of testing _____	0 3 7 10		
	Total Score:		

Following are examples used to determine generally a student's characteristics as they are related to therapy; a student need not exhibit every characteristic in a column in order to qualify for a designated level of service.

	a	b	c	d
1. **AGE**	17-21	13-16	7-12	6 or under
2. **OBSERVED RATE OF CHANGE**	No change in developmental milestones or quality of movement has occurred in the past year.	Minimal change in developmental milestones or quality of movement has occurred in past year.	Change is continuing, or potential for change is unclear.	Change is rapid or appears to have potential to become rapid.
3. **EFFECTS OF THERAPEUTIC INTERVENTION**	Student has received therapy of appropriate intensity and duration, and has received maximum benefit from it. Student is maintaining expected level of functioning.	Student has received therapy of appropriate intensity and duration and has plateaued and/or is maintaining expected level of functioning.	Student has received therapy and continues to make progress, or has received no therapy in the past and potential is unknown.	Student has received therapy and continues to make significant progress, or has had no appropriate opportunity for therapy and appears to have potential for significant gains.
4. **EXPECTED RESPONSE TO TREATMENT**	No change in functioning is expected to result from treatment; no input from therapist is needed to maintain functioning.	Minimal change is expected to result from treatment.	Some change is expected; maintenance of function, or prevention of deterioration is expected to result from treatment.	Significant progress is expected to result from treatment.

	a	b	c	d
5. NATURE OF DISABLING CONDITION	Interferes in no way with participation in, and ability to benefit from, educational environment; and is not a degenerative condition.	Has the potential to interfere with, minimally limits function in the educational environment, or is a degenerative condition that currently requires monitoring and/or minimal therapy intervention.	Interferes with appropriate participation in, and ability to benefit from, the educational environment; or is a degenerative condition which currently requires some intervention by a therapist to maintain maximum possible functioning.	Prevents appropriate participation in, and ability to benefit from, the educational environment; or is a degenerative condition which currently requires much intervention to maintain maximum possible functioning, and design adaptations as needed.
6. POSSIBILITY OF NEEDS BEING MET BY OTHERS	Student has no therapy-related needs.	Needs could be met by others with only infrequent, minimal therapist involvement. This could include setting up a school home program; supplying materials or equipment; instructing others to position and handle the student; periodically checking or consulting on request.	Some direct therapy may be required, but many needs can be met by an aide with regular input, monitoring and evaluation by a therapist. Therapist is needed to promote understanding and involvement of parents and teachers to enhance student's functioning and development.	Most therapy-related needs can be met only by direct, regular, frequent therapy, and/or therapist is needed to intensively instruct parents, teachers, or aides; to provide adaptive equipment or other extensive indirect services to enable others to meet the student's needs.

	a	b	c	d
7. **IMMEDIACY OF NEED FOR SCHOOL THERAPY**	School therapy is unneeded or inappropriate.	Therapy services could be beneficial, but interruption or postponement would not cause significant problems.	Therapy services should be reevaluated because student is in a transitional period; e.g., student is experiencing a recent growth spurt, adolescence, a move from one school setting to another, and/or vocational life-planning issues that may require trial and/or short-term therapy intervention.	Therapy services should be continued or initiated as soon as possible because of concern about educational performance; ability to be maintained in the least restrictive environment; lack of function; or deformity. Needed therapy services have been postponed or impairment is of recent onset.
8. **THERAPY IN RELATION TO OTHER DEMANDS ON THE CHILD'S TIME**	School therapy is unneeded, or inappropriate.	Intervention by a therapist has a lower priority than other educational needs. Therapy-related activities should consume little student time.	Therapy needs are as great as other educational program needs and therapy-related activities (e.g., direct therapy, classroom activities) require a moderate portion of the student's school time.	Therapy needs are greater than other educational needs and require that a significant portion of the student's time in school be spent on therapy-related activities (e.g., direct therapy, classroom activities).
9. **STUDENT'S BEHAVIOR**	Consistently prevents therapy from being beneficial.	Neutral, and does not interfere with ability to benefit from therapy.	Cooperative and shows some motivation to achieve therapy goals.	Shows a high level of motivation to achieve therapy goals. Student actively participates in therapy.

	a	b	c	d
10. INTELLECTUAL FUNCTIONING *	Severe to profound mental retardation: intellectual functioning level is or may be the primary factor limiting motor development.	Moderate to severe mental retardation: acquisition of motor skills is limited by intellectual functioning.	Range of mild mental retardation: acquisition of motor skills may be limited by intellectual functioning.	Normal or above normal: functioning does not limit acquisition of motor skills.

*Categories a, b, and c under item number 10 can be completed only on the basis of intellectual testing conducted within the last three years. If test data are unavailable, score these categories N/A (not available). Category d can be scored if (written) data are available that indicate the student is progressing successfully through the regular curriculum. Such data may be passing grades or better on report cards, achievement test scores that are in the average range or above, or teachers' reports.

Developed by Penny Reed, Ph.D.; Nancy Cicirello, P.T.; and Sandra Hall, O.T.R.; 1988

APPENDIX B

SERVICE DELIVERY MODEL

All students receiving occupational/physical therapy services are assessed and assigned one of four levels of service. The levels of service are based on the rate of change in the student's physical/functional status and may change during the school year. Each level of service defines the purpose of intervention, intensity of service, and the personnel responsible for the delivery of services. Therapists are involved in evaluation, therapy service planning, parent/staff training, and monitoring of student's programs.

Level	Physical/Functional Status of Student	Purpose of Intervention	Intensity of Service	Therapist/Staff Involvement
I	Student is undergoing rapid and/or crucial change in physical/ functional status.	Therapy goals are designed to develop functional level or prevent significant regression.	Time commitment may range from 2½ – 3½ hours per week; of that, 2/3 is targeted on time with student, 1/3 is targeted time on behalf of student. Therapy revisions are frequent.	Physical needs are primarily addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
II	Student is undergoing moderate change in physical/functional status.	Therapy goals are designed to develop functional level.	Time commitment may range from 1½ – 2½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are periodically necessary.	Physical needs are addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
III	Student's physical/ functional status is undergoing some change or is stable.	Therapy goals are designed to develop and/or maintain functional level.	Time commitment may range from ½ – 1½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are infrequent.	Therapist is now in a more supportive role, with other personnel involved as appropriate in order to provide a "therapeutic day."
IV	Student's physical/ functional status is stable.	Therapy goals are designed to monitor functional and physical status.	Time commitment is up to 20 hours per school year. Contact frequency may vary (bimonthly, monthly, quarterly). Student may be placed on Level IV to monitor status prior to dismissal.	Therapist will monitor on a needs basis, providing input on student's needs as appropriate. Other personnel may need to continue to follow through on simple recommendations in order to help maintain the student's physical/ functional status.

EXAMPLES OF DELIVERY MODEL LEVEL STUDENTS

I. Level One

Young student (3-5 years old) with cerebral palsy. The student is new to the school system and continues to show significant functional changes in ambulation and mobility skills with therapy (example: child has just begun to walk).

Student receives learning disability program with a progessive neurological disorder of unknown cause. This student has been mainstreamed into a regular classroom and is undergoing crucial functional changes in the following areas: (1) loss of head control necessary for visoual attending to classwork, (2) loss of independent sitting balance at desk, (3) loss ob hand skills, and (4) loss of independent mobility.

II. Level Two

Elementary grade student in a learning disability program who has cerebral palsy (hemiplegic). With therapy, the student continues to show steady functional gains in the following areas: (1) bilateral hand skills (cutting, manipulating clothing fasteners, ball catching), (2) self-care, (3) gross motor coordination (example: child can climb stairs).

A young, developmentally delayed student receiving programming in early childhood. This is the "clumsy" student, who, with therapy, continues to make gains in the motor prerequisites (such as basic functional balance, weight shifting, postural control) necessary for skills development. Problem areas seen in the classroom may be poor attention span, distractability, poor desk posture, motor planning problems (poor organizing of work, following directions, cutting, coloring) and awkwardness in gross motor movements compared to other students of the same age.

III. Level Three

Student with spina bifida receiving specially designed physical education. This student has essentially reached a plateau in development skills (head control, sitting ability, mobility); however, the potential exists for physical regression (increasing muscle tightness, dislocated hip, skill breakdown) which could interfere with classroom programming without regular supportive input from a therapist.

Student with spina bifida who has become functional within the school setting. The student's physical status and cognitive level is age appropriate, but student continues to need intervention to improve on quality and endurance in these skills and to enhance other skills during growth and maturation (examples: stair climbing, bus transferring, toileting).

IV. Level Four

Middle or high school student receiving special education services. Owing to years of previous therapy, this student's physical/functional status has stabilized or reached a plateau. Therapy intervention is necessary to monitor status and/or equipment to ensure that classroom needs are being met.

Student receiving specially designed physical education. This student displays delayed gross motor skills and poor quality of movenets compared to other students of same age; however, the student has had several years of therapy, with the physical/functional status reaching a plateau. Mental retardation, behavior problems, and/or poor cooperation may be interfering with further progress. School personnel are familiar with incorporating appropriate therapy-related techniques into classroom program. Student may be placed on Level IV to monitor status prior to dismissal.

From Waukensha Delivery Model: Providing Occupational/Physical Therapy Services for Special Education Students. Wisconsin Department of Public Instruction, 1987.

APPENDIX C

LINCOLN COUNTY SCHOOL DISTRICT
PO BOX 1110
NEWPORT, OREGON 97365

REQUEST FOR MOTOR TEAM SERVICES

(THIS FORM MUST ACCOMPANY A FOCUS OF CONCERN)

APE/OT/PT

TEACHER NAME: _____

STUDENT NAME: _____ AGE OF STUDENT: _____

SCHOOL: _____

1. Does this student have difficulty moving about in the classroom? YES NO

2. Does this student exhibit unusual standing or running posture? YES NO
   If yes, describe (under what conditions): _____

   _____

3. Sitting Posture:
   A. Body Position: Eyes close to paper: YES NO
   Lean on desk? YES NO
   Trunk position-erect? YES NO
   slouching? YES NO

   B. Does the student stay seated? YES NO

4. General activity level: High Average Low

5. Desk location: Isolated, Close to teacher, Close to chalkboard, special desk, other:

   _____

   _____

6. Describe pencil skills:
   A. Pencil handling (grasp and coordination): _____

   _____

   B. Quality of work compared to class: _____

   _____

   C. Extra time required to complete written work? YES NO

   D. Reversals? Describe: _____

   _____

   E. Unusual hand/arm movement (shakiness/tremor)? Describe: _____

   _____

   F. Organization of work on a page: Left to Right YES NO
   Top to Bottom YES NO
   Appropriate Spacing YES NO
   Other: _____

   _____

7. Has student developed consistent use of one hand for fine motor tasks? YES NO
   Which hand shows dominance? RT LFT

8. Does student have difficulty with scissor skills? YES NO

9. Are self care skills a problem: Hygiene YES NO

Describe: _____

Toileting YES NO

Describe: _____

Feeding YES NO

Describe: _____

10. Does student complain of pain during physical activity YES NO

If yes, when/what kind? _____

_____

PHYSICAL EDUCATION SECTION

(To be completed by the Physical Education Teacher)

1. Physical education class: Day/Time: _____

PE Teacher's Name: _____

2. PE Setting:
   - A. Self-contained with class room aide?
   - B. Self-contained with physical education teacher?
   - C. Mainstreamed with physical education teacher?
   - D. Mainstreamed with teacher?
   - E. No physical education?

3. Describe behavior during PE class: (circle)

Compliant Disruptive Aggressive Isolative

Comments: _____

_____

4. Describe motor function during PE class:

	POOR	FAIR	GOOD
A. Fundamental motor skills			
B. Physical fitness			
C. Balance			
D. Eye-hand coordination			
E. Understanding rules			

5. Describe how this student compares with peers during physical education: _____

_____

_____

6. Specific motor functioning problems: Explain Gross Motor problems, tracking difficulties, inability to follow/process directions, etc.: _____

_____

_____

Revised by Lincoln County Motor Team
April 1986

APPENDIX D

ORS 342.850

TEACHER EVALUATION; FORM; PERSONNEL FILE CONTENT

(1) The district including superintendents of education service districts, shall cause to have made at least annually but with multiple observations an evaluation of performance for each probationary teacher employed by the district and at least biennually for any other teacher. The purpose of the evaluation is to allow the teacher and the district to determine the teacher's development and growth in the teaching profession and evaluate the performance of the teaching responsibilities. A form for teacher evaluation shall be prescribed by the State Board of Education and completed pursuant to rules adopted by the district school board.

(2) (a) The district school board shall develop an evaluation process in consultation with school administrators and with teachers. If the district's teachers are represented by a local bargaining organization, the board shall consult with teachers belonging to and appointed by the local bargaining organization in the consultation required by this paragraph.

(b) The district school board shall implement the evaluation process that includes:

(A) The establishment of job descriptions and performance standards which include but are not limited to items included in the job description;

(B) A preevaluation interview which includes but is not limited to the establishment of performance goals for the teacher, based on the job description and performance standards;

(C) An evaluation based on written criteria which include the performance goals; and

(D) Post-evaluation interview in which (i) the results of the evaluation are discussed witht he teacher and (ii) a written program of assistance for improvement. if needed, is established.

(c) Nothing in this subsection is intented to prohibit a district from consulting with any other individuals.

(3) Except in those districts having an average daily membership, as defined in ORS 327.006 of fewer than 200 students, the person or persons making the evaluations must hold teaching certificates. The evaluation shall be signed by the teacher. A copy of the evaluation shall be deliver to the teacher.

(4) The evaluation reports shall be maintained in the personnel files of the district.

(5) The evaluation report shall be placed in the teacher's personnel file only after reasonable notice to the teacher.

(6) A teacher may make a written statement relating to any evaluation, reprimand, charge, action or any matter placed in the teacher's personnel file and such teacher's statement shall be placed in the personnel file.

(7) The personnel file shall be open for inspection by the teacher, the teacher's designees and the district school board and its designees. District school boards shall adopt rules governing access to personnel files, including rules specifying whom school officials may designate to inspect personnel files. [1971 c.570-5; 1973 c.298-3; 1973 c.458-1; 1977 c.881-3; 1979 c. 598-1; 1979 c.668-2a]

A Model Performance Appraisal Instrument for School Physical Therapists

by Dianne Lindsey

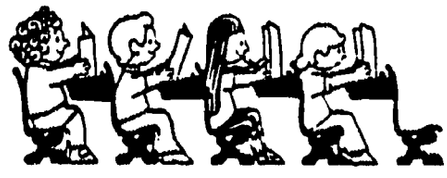
Legislators, administrators, and educators have long recognized that program evaluation, as well as individual performance appraisals, are common denominators to the effective delivery of educational services. Federal and state laws have provided mechanisms to evaluate and improve special education for handicapped students. Special educators support open and objective evaluation procedures that help them review and improve the special programs for which they are responsible. There has been a growing need for evaluation tools that are specifically developed to help support and evaluate the increasing number of related support personnel who have been employed in educational environments for the past several years. Only within recent years have individual performance appraisal instruments been developed to assess the impact of physical therapists on the education of handicapped students. An individual performance appraisal tool for physical therapists has been developed by the North Carolina Department of Public Instruction, and is being field tested at this time.

This article describes the development of a school physical therapist performance appraisal instrument currently being field tested by the North Carolina Department of Public Instruction. Samples of the instrument are included.

The need

In response to the growing need for accountability within education as well as to comply with legal requirements. Section 35 of the 1980 North Carolina General Assembly Appropriations Act provided a mandate requiring the development of criteria and performance standards to be used in evaluating professional public school employees.

Acting in compliance with the mandate, a three-day workshop was held where a group of nine school physical therapists, two local directors of special programs, the state physical therapy consultant, and two state level special education administrators met to develop the appraisal content necessary to develop an instrument to evaluate school physical therapists.



It was established that the purpose of performance appraisal is to provide an opportunity for school physical therapists to continually improve on-the-job performance as well as to improve and expand physical therapy programs. The evaluation process should also encourage professional growth and development; provide employee satisfaction in knowing how well the job is being accomplished; provide information to supervisors concerning the physical therapy program, its services, its accomplishments, its need for recognition and support; and contribute to the effectiveness by which the therapist achieves goals and objectives. Of course, the cornerstone of a performance appraisal system is to support the therapist and provide a means for rational and objective personnel decisions.

Many physical therapists were concerned about being evaluated by non-physical therapy administrators; it was decided that the requirements of this legislative mandate should be met without requiring non-physical therapy supervisors to evaluate specific physical therapy evaluation and treatment techniques.

Instrument development

Using these established needs as a guideline. the Physical Therapy Performance Appraisal Instrument was developed to provide:

- Information to improve physical therapist job performance
- Information to administrators concerning the physical therapist's and the physical therapy programs strengths, weaknesses, and needs
- Information necessary to make personnel decisions related to physical therapists and their programs
- A performance appraisal tool that was acceptable to physical therapists, administrators, and evaluators
- An evaluation tool that was appropriate for non-medical or non-physical therapist evaluators to use

- Performance criteria and indicators that represented acceptable educational and physical therapy practice
- A performance appraisal process that would promote a partnership between physical therapists and administrators.

Functional design

The design of the Physical Therapy Performance Appraisal Instrument identifies major functions related to the job. Each major function has a number of performance indicators (Sample Evidences) which, when performed collectively, indicate the therapist is carrying out the major job function. To determine whether a therapist is performing a function, evidence should be provided that enables an evaluator to determine the degree to which that indicator is being performed by the therapist. A rating scale specifies the degree or level of performance of the therapist being evaluated.

The Instrument appears here in three parts. The official job description of the school physical therapist is listed first with the therapist's perceived major functions delineated. Next, Sample Evidences are provided for each of these major functions, to be used as a guideline for evaluating performance. Lastly the actual form for use in appraising performance is presented. We welcome feedback and suggestions concerning this evaluation instrument.

Appreciation goes to Dr. Donn Dieter, Division of Personnel Relations and David Mills, Division for Exceptional Children, North Carolina Department of Public Instruction, for their guidance in helping develop the Physical Therapy Performance Appraisal Instrument. Thanks also to the school physical therapists whose knowledge and input were vital to the success of this project.

Dianne Lindsey, PT, is State Physical Therapy Consultant, North Carolina Dept of Public Instruction, 2210 B Daley Road, Chapel Hill, NC 27514.

JOB DESCRIPTION
PHYSICAL THERAPIST

REPORTS TO: Director of Exceptional Children/Superintendent(s)

SUPERVISES: May supervise Professionals, Paraprofessionals, and/or Clerical Staff

PURPOSE: To promote the education of handicapped students by (1) providing screening, evaluation, intervention, and consultative services, and by (2) providing information to, and establishing relationships with, educational personnel and community agencies regarding total program planning for the handicapped student.

MAJOR FUNCTIONS

A. Identification and Planning

The physical therapist observes, screens, and evaluates students with physical/motor disabilities, interprets assessment results, and plans for appropriate intervention services.

B. Service Delivery

The physical therapist develops and implements direct, indirect, and consultative services based on individual assessment results and planned intervention goals.

C. Program Administration and Management

The physical therapist participates in the local education agency's comprehensive planning process for the education of exceptional children. The physical therapist establishes the procedures for implementing a physical therapy program and participates in the administration, management, and maintenance/expansion of the physical therapy program.

D. Education

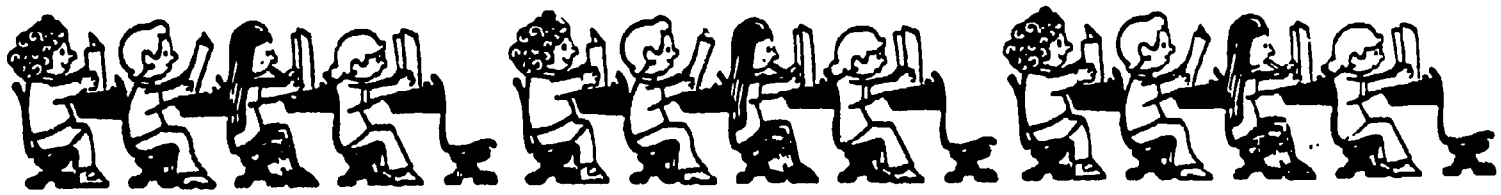
The physical therapist provides information to develop and maintain support for the objective of physical therapy services and establishes relationships with administrators, school personnel, parents, and nonschool agencies to facilitate the education of students with physical/motor disabilities. The physical therapist provides clinical internship opportunities.

E. Professional Growth and Ethics

The physical therapist adheres to the ethical standards of the profession and seeks to develop professionally. The physical therapist adheres to established rules, regulations and laws, and works cooperatively to accomplish the goals and objectives of the local education agency.

Figure. The formal job description of the physical therapist, to be used when evaluating performance.

"It was decided that the requirements [of performance appraisal] should be met without requiring non-physical therapy supervisors to evaluate specific physical therapy . . . techniques."



SAMPLE EVIDENCES
PHYSICAL THERAPIST

The following are suggested as examples of performance that might be displayed by the person being evaluated as evidence that each of the various functions are being performed. Because each work situation is different, it is not likely that all of these will be demonstrated by the physical therapist being evaluated. The evaluator is urged to develop a similar list of expectations that are specific for the person being evaluated.

MAJOR FUNCTIONS

A. Identification and Planning

1. Receives and records initial referral information and requests.

   Sample Evidences:
   a. keeps records on students referred, including numbers and dates of referral
   b. acknowledges and responds to referral

2. Observes referred students as appropriate.

   Sample Evidences:
   a. schedules observation time with school personnel
   b. makes results of observation available to school personnel
   c. documents appropriate responses and/or follow-up

3. Obtains additional or supplementary information from appropriate persons, available records, and/or agencies.

   Sample Evidences:
   a. obtains and reviews medical records and pertinent history using appropriate release forms
   b. reviews available educational records
   c. communicates with parents, school personnel, other professionals and agencies

4. Conducts screening and/or evaluations using formal and informal tests.

   Sample Evidences:
   a. obtains necessary permissions
   b. acts as member of interdisciplinary team
   c. administers tests according to acceptable procedures
   d. keeps records of screening/evaluation results and follow-up

5. Documents, analyzes, and interprets data.

   Sample Evidences:
   a. integrates data from a variety of assessment techniques and sources
   b. determines the effect of the impairment on the student
   c. writes reports of screening/evaluation results
   d. makes confidential reports available to authorized school staff, parents, physicians, agencies, and central administrative office personnel
   e. participates on school-based/school administrative committees

6. Makes recommendations for intervention and refers to other services as appropriate.

   Sample Evidences:
   a. refers to other services when appropriate
   b. documents need for direct/indirect or consultative physical therapy service
   c. documents if no follow-up is necessary
   d. follows up on recommendations and referrals

7. Plans intervention goals and activities for individual students and/or groups.

   Sample Evidences:
   a. develops treatment goals and activities
   b. develops classroom goals and activities
   c. schedules intervention time
   d. identifies management team when necessary
   e. locates and prepares intervention areas
   f. reassesses goals and activities and modifies program if appropriate on a continuing basis

8. Coordinates information and services with school personnel and community agencies.

   Sample Evidences:
   a. explains purpose of recommendations to parents, professionals, school personnel, and agencies
   b. helps to explore and coordinate everyone's efforts in achieving physical therapy objectives and goals
   c. documents all related efforts and contacts

B. Service Delivery

1. Provides direct and indirect physical therapy intervention for individual students and groups.

   Sample Evidences:
   a. uses methods, equipment, and techniques as stated in intervention plan
   b. provides for equipment and material needs (assess, obtain, construct, modify, repair)
   c. assists in ensuring architectural accessibility and safety
   d. assists in ensuring transportation accessibility and safety
   e. assists in adapting physical education programs
   f. assists in ensuring emergency standards and procedures
   g. re-assesses student status and progress on a continuing basis

2. Instructs, supervises, and monitors home and school personnel in the therapeutic management of students.

Sample Evidences:

a. trains in positioning and physical handling techniques
b. trains in therapeutic activities
c. trains in equipment and material use
d. trains in safety measures
e. monitors and supervises skills of personnel implementing these programs..

3. Consults with home and school personnel regarding needs of individual students.

Sample Evidences:

a. seeks information on student status, progress, and needs
b. seeks information and identifies needs regarding family and school personnel's current management of the student
c. discusses intervention goals, activities, and progress
d. recommends referral to school support services
e. assists in student placement in the least restrictive environment
f. participates as a team member in service determination, provision, and review

4. Consults with outside agencies and non-school personnel regarding needs of individual students.

Sample Evidences:

a. recommends referral to community services
b. exchanges information on individual student status and services
c. coordinates student's school physical therapy services with non-school services
d. attends clinics as appropriate

5. Maintains and documents intervention procedures and results, using forms, records, and reports.

Sample Evidences:

a. obtains parent permission for intervention
b. obtains physician referral for intervention if needed
c. documents contacts, treatments, and re-evaluations regarding individual students
d. documents all related contacts with non-school agencies and personnel

C. Program Administration and Management

1. Organizes and implements a physical therapy program which addresses educational goals and policies.

Sample Evidences:

a. contributes to the development of program policy, guidelines, and projections
b. cooperates with local education agency, community and/or state agency, and programs to effect comprehensive education services

2. Manages quality physical therapy services.

Sample Evidences:

a. supervises physical therapy staff and student interns
b. conducts physical therapy staff meetings
c. sets student service priorities
d. establishes long-range physical therapy program goals
e. evaluates the effectiveness of the physical therapy program and makes necessary modifications
f. manages time efficiently
g. maintains inventories of equipment, materials, and supplies
h. assists in the employment of physical therapy personnel
i. demonstrates budget planning skills
j. promotes effective interpersonal and interdisciplinary relationships

3. Establishes and maintains appropriate record keeping and reporting system.

Sample Evidences:

a. develops necessary forms
b. keeps data for program planning, decision making, and program expansion
c. maintains current administrative files and records
d. safeguards confidentiality of student records

4. Participates in total program planning as central administrative team member.

Sample Evidences:

a. contributes to long-range planning for exceptional children programs
b. participates in program planning to ensure least restrictive environment
c. assists with planning for special transportation
d. assists with planning for architectural accessibility
e. participates in curriculum planning
f. participates in program coordination with non-school agencies

D. Education

1. Provides ongoing information for administrative personnel regarding physical/motor disabilities, physical therapy services, and implications for student placement.

Sample Evidences:

a. promotes awareness of the role and function of physical therapy within the public school system
b. serves as a consultant to administrative staff regarding medical information
c. provides information to help prevent secondary physical and emotional problems related to disability
d. alerts personnel to safety issues and procedures
e. shares information to facilitate inter-departmental coordination
f. provides input on space and personnel needs for students with physical/motor disabilities

2. Provides formal and informal inservice education for all levels of educational and support personnel.

Sample Evidences:

a. assesses and documents inservice needs

b. develops inservice plan and implements it
c. makes resource material available to personnel

3. Provides information on an informal and formal basis to parents and non-school personnel regarding physical therapy and educational services.

Sample Evidences:

a. speaks to parents, community organizations, health agencies, and professional groups
b. develops and shares information materials
c. assists in organizing parent education and support

4. Provides clinical internship opportunities for students enrolled in physical therapy and physical therapist assistant programs.

Sample Evidences:

a. informs physical therapy and physical therapist assistant programs of opportunities in school settings
b. develops contractual agreements for student internships
c. develops goals and procedures for clinical internships

E. Professional Growth and Ethics

1. Participates in professional growth activities and continuing education opportunities.

Sample Evidences:

a. participates in professional meetings and workshops
b. reviews literature
c. exchanges information with peers
d. participates in clinical research or utilizes clinical educational research information

2. Integrates current professional knowledge and skills into physical therapy program.

Sample Evidences:

a. applies knowledge and skills gained from professional growth and continuing education activities
b. explores, studies, and disseminates information concerning new or improved methods for serving students

3. Adheres to ethical standards of the physical therapy profession.

Sample Evidences:

a. maintains current North Carolina license
b. provides services that hold the wellbeing of each student paramount
c. maintains confidentiality of student information

4. Supports efforts to accomplish the goals and objectives of the local education agency.

Sample Evidences:

a. reflects a positive attitude to the community
b. serves on committees and participates in school meetings

5. Adheres to established rules, regulations, and laws.

Sample Evidences:

a. demonstrates knowledge of federal, state, and local rules, regulations, and laws
b. complies with established rules, regulations, laws

PERFORMANCE APPRAISAL CRITERIA
PHYSICAL THERAPIST

Physical Therapist's Name _____

Location _____

Instructions

1. *The evaluator is to rate the physical therapist on a five-point scale as indicated below.*
2. *The evaluator is encouraged to add pertinent comments at the end of each major function.*
3. *The physical therapist is provided an opportunity to react to the evaluator's rating and comments.*
4. *The evaluator and the physical therapist must discuss the results of the appraisal and any recommended action pertinent to it.*
5. *The physical therapist and the evaluator must sign the instrument in the assigned spaces.*
6. *The instrument must be filed in the physical therapist's personnel folder.*

Rating Scale
(Check the appropriate box)

Performs Unsatisfactorily	Needs Improvement In Performance	Meets Performance Expectations	Exceeds Performance Expectations	Superior Performance	Not Applicable

A. Identification and Planning

1. Receives and records initial referral information and requests.
2. Observes referred student as appropriate.
3. Obtains additional or supplementary information from appropriate persons, agencies, and/or available records.
4. Conducts screening and/or evaluations using formal and informal tests.
5. Documents, analyzes, and interprets data.
6. Makes recommendations for intervention and refers to other services as appropriate.
7. Plans intervention goals and activities for individual students and/or groups.
8. Coordinates services and provides information to school personnel and community agencies.

Comments _____

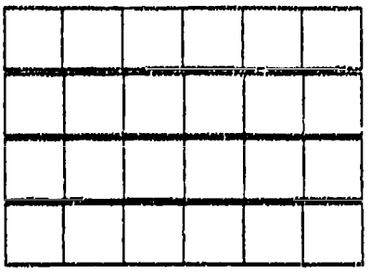
B. Service Delivery

1. Provides direct and indirect physical therapy intervention for individual students and/or groups.
2. Instructs, supervises, and monitors home and school personnel in the therapeutic management of students.
3. Consults with home and school personnel regarding needs of individual students.
4. Consults with outside agencies and non-school personnel regarding needs of individual students.
5. Maintains and documents intervention procedures and results using forms, records, and reports.

Comments _____

C. Program Administration and Management

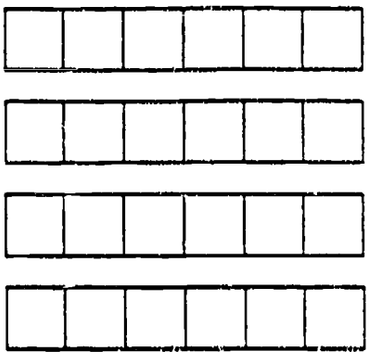
1. Organizes and implements a physical therapy program which addresses education goals and policies.
2. Manages quality physical therapy services.
3. Establishes and maintains appropriate record keeping and reporting system.
4. Participates in total program planning as a central administration team member.



Comments _____

D. Education

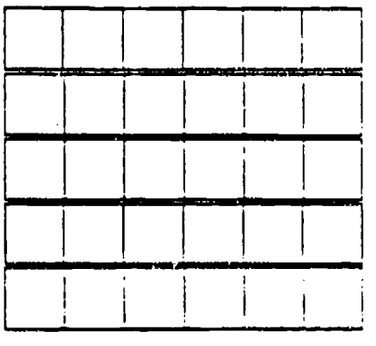
1. Provides on-going information for administrative personnel regarding physical/motor disabilities, physical therapy services and implications for student placement.
2. Provides informal and formal inservice education for all levels of educational and support personnel.
3. Provides information on an informal or formal basis to parents and/or non-school personnel regarding physical therapy programs and educational services.
4. Provides clinical internship opportunities for students enrolled in physical therapy schools and physical therapist assistant programs.



Comments _____

E. Professional Growth and Ethics

1. Participates in professional growth activities and continuing education opportunities.
2. Integrates current professional knowledge and skill into physical therapy programs.
3. Adheres to the ethical standards of the physical therapy profession.
4. Supports efforts to accomplish the goals and objectives of the local education agency.
5. Adheres to established rules, regulations, and laws.



Comments _____

Evaluator's Summary Comments _____

Physical Therapist's Reaction to Evaluation _____

Evaluator's signature and date

Physical Therapist's signature and date

Signature indicates that the written evaluation has been seen and discussed

APPENDIX F

RECRUITMENT AND RETENTION OF PEDIATRIC PHYSICAL AND OCCUPATIONAL THERAPISTS

Susan K. Effgen, Ph.D., LPT
Curriculum Coordinator Pediatric Physical Therapy
Assistant Professor of Orthopedic Surgery & Rehabilitation
Hahnemann University
Philadelphia, PA

Across the nation one frequently hears about the critical shortage of physical and occupational therapists. There is indeed a shortage, however not to the extreme extent that many might believe. Nor is there a lack of interest of working with children having special needs. In fact, the desire to help special children is frequently the reason students seek careers in physical or occupational therapy.

The first purpose of this presentation is to familiarize the audience with the appropriate avenues of recruitment for pediatric physical and occupational therapists. How to network within the therapists' own professional circles will be emphasized. The issue of recruiting experienced and inexperienced therapists will be discussed.

The second purpose of the this presentation will be on how to retain and facilitate the professional development of therapists once recruited. Issues such as supervision, salary, case load and continuing education will be presented. Special attention will be given to the unique needs of the inexperienced therapist and the therapist working in isolation from other pediatric therapists.

The audience will hopefully gain knowledge of different resources to use in their recruitment efforts and a better appreciation of the needs of therapists in terms of job satisfaction and professional growth and development.

I. Placement Chairman

The American Occupational Therapy Association (ACTA) and the American Physical Therapy Association (APTA) both have individual state placement chairmen. These individuals usually maintain a current listing of positions available in their states. Some states require a fee to have a position listed and some states have a fee to obtain the list. These placement chairmen are usually very knowledgeable concerning employment situations in their area and can serve as excellent resources. A current listing from both the AOTA and the APTA is enclosed.

II. Classified Advertisements

Occupational Therapy

OT Weekly

Individual State Chapter Newsletters

Contact state placement chairman for specific state information

Physical Therapy

Journal of the American Physical Therapy Association
Classified Ad Department
American Physical Therapy Association
1111 N. Fairfax Street
Alexandria, VA 22314
(703) 684-2782, Ext. 426
All ads must be received by the first of the month preceding publication.

APTA Section on Pediatrics - Totline
Job Placement Editor
Kathleen Kelleher
65 Howley Drive
Morrisville, PA 19067
Totline is published four times a year.

Individual State Chapter Newsletters

Contact state placement chairman for specific state information

Occupational and Physical Therapy

Physical Therapy Forum
Occupational Therapy Forum
251 W. DeKalb Pike Ste. A-115
King of Prussia, PA 19046
(215) 337-0381
Advertisement newsletter which comes out weekly in four regional editions. It is mailed free of charge to licensed PTs, PTAs, OTRs and COTAs throughout the U.S. Deadline is one week before Wednesday publication.

TASH: The Association for Persons with Severe Handicaps Newsletter
7010 Roosevelt Way, NE
Seattle, WA 98115
(206) 523-8446

TEACHING Exceptional Children
Exceptional Children
Classified Advertising
Department of Information Services
Council for Exceptional Children
1920 Association Drive
Reston, VA 22091-1589

Neuro-Developmental Treatment Association Newsletter
P.O. Box 14613
Chicago, IL 60614
Local Physical and/or Occupational Therapy Special Interest Group Newsletters

Local Newspapers

III. Other Recruitment Methods

Booth at National or State AOTA or APTA meetings

Booth at Continuing Education Programs
Send staff to help recruit

Provide refreshments at local Special Interest Group meetings

Handle Special Interest Group meetings or newsletter

Contact Universities with Physical or Occupational Therapy Programs. Accredited occupational therapy programs are listed in the November issue of the American Journal of Occupational Therapy. Accredited physical therapy programs are listed in the October issue of the Journal of the American Physical Therapy Association. Get to know the university faculty in your area teaching in pediatrics and volunteer your resources.

Hire a professional employment agency which specializes in Health Care Professionals.

Participate in Occupational or Physical Therapy Job Fairs.

Provide scholarship support to an occupational or physical therapy student.

Accept affiliating occupational or physical therapy students. You need to already have an experienced therapist on staff. If you have attempted to get a student but were unsuccessful, try offering free room and board.

LOCATION

According to Kaplan's (1984) study, location is the most critical factor in job acceptance. Remember that you can attract therapists to move to some areas whereas at other locations you must recruit locally. Also, carefully consider implications of relocating a therapist to another agency or system facility.

SALARY

Salary is always important and reflects self worth and value. Pediatric therapists generally earn less than their counterparts in hospitals and other health care settings. Flexible hours, shorter work days and shorter work years can not always account for the major salary differentials seen. Try to avoid expensive contracts by raising salary levels. This may be more difficult administratively but it is better long term for staff and facility development. Remember the old saying, "You get what you pay for."

CONTINUING EDUCATION

Continuing education is the major avenue of achieving the skills necessary to be a competent pediatric therapist (Heriza, Lunnen, Fischer, Harris, 1982; Gilfoyle, 1980; Kaplan, 1984; Levangie, 1978). Providing opportunities for continuing education is of significant importance in recruiting and retaining therapists. I believe that continuing education must be mandatory for all pediatric therapists and should be contingent for continued employment. However, the employer should provide the release time, registration fees and a portion of the travel expenses. Most diligent therapists agree and are frequently willing to give up their weekends to attend continuing education courses. Tuition waivers for graduate education does not appear to be that important to practicing therapists (Effgen, 1985; Kaplan, 1984). A significant reason for this is probably the very limited number of graduate programs available nationwide in pediatric occupational or physical therapy. Taking courses in other disciplines while helpful, does not meet the unique professional needs of the therapist.

CLIENT POPULATION

Pediatric therapists wish to work with children. Generally, the younger the better. Providing a very young or at least a diversified age client population is important. Degree and type of handicap of the client population appears to have varying impact on retention or recruitment of therapists. In general, therapists prefer a cross-section of disability levels and diagnoses. Always working with those have severe, profound handicaps or those who are terminally ill can lead to more rapid therapist attrition.

SUPERVISION

Therapists need to be supervised by therapists. Although educators and physicians have a lot to offer therapists, they are unable to assess or facilitate the development of clinical skills and competence. Peer review must be just that -- review by one's own peers.

ACCESS TO OTHER THERAPISTS

Several studies (Effgen, 1985; Kaplan, 1984) have indicated that access to another therapist is very important. It allows for exchange of information, tutoring, mentoring, and in general encourages professional development.

SPACE AND EQUIPMENT

Kaplan's (1984) study found space to be rated second and equipment fourth in importance in attracting physical therapists for employment. The present study by Effgen (1985) has found these not to be considered as critical in attracting physical therapists, however their importance in terms of job satisfaction and retention of therapists must not be underestimated.

REFERENCES

Effgen, S. (1985). [Recruitment and Retention of Pediatric Physical Therapists]. Unpublished raw data. Hahnemann University, Philadelphia.

Gilfoyle, E.M. (Ed.). (1980). Training: Occupational Therapy Educational Management in Schools. Rockville, Maryland: American Occupational Therapy Association

Heriz, C., Lunnen, Kl, Fischer, I. & Harris, M. (1983). Pediatric Practice in Physical therapy. Physical Therapy 63, 948-956.

Kaplan, S. (1984). Why Aren't There More of You? A descriptive and correlational study of physical therapists in Ohio's developmental settings. Unpublished master's thesis, Ohio State university, Columbus.

Levangie, P.K. (1980). Public school physical therapists. Physical Therapy, 60, 774-779.

Presented at the 1985 TASH Conference, Boston.

APPENDIX G

DIRECTORY OF EDUCATIONAL PROGRAMS IN PHYSICAL THERAPY

Programs listed here are accredited by the Commission on Accreditation in Education, American Physical Therapy Association

Bachelor's Degree, Master's Degree, and Certificate Programs

Key
(1A) Bachelor's degree course.
(1B) Accepts candidates for second Bachelor's degree.
(2) Certificate course.
(3) Bachelor's degree available from affiliating college or university.
(4) Accepts women only.
(5) Entry-level Master's degree program.

ALABAMA

UNIVERSITY OF ALABAMA AT BIRMINGHAM (5). Div of Physical Therapy, RTI Bldg, Rm B-41, University Station 35294 (Marilyn R. Gossman, PhD).

UNIVERSITY OF SOUTH ALABAMA (1A, 1B). Dept of Physical Therapy, College of Allied Health Professions, Allied Health Bldg, Mobile 36688.

ARIZONA

NORTHERN ARIZONA UNIVERSITY (1A, 1B). Dept of Physical Therapy, School of Health Professions, CU Box 15105, Flagstaff 86011 (Carl DeRosa).

ARKANSAS

UNIVERSITY OF CENTRAL ARKANSAS (1A, 1B). Dept of Physical Therapy, 1211 Wolfe St, Ste 235, Little Rock 72202 (Venita Lovelace-Chandler).

CALIFORNIA

CALIFORNIA STATE UNIVERSITY, FRESNO (1A). Physical Therapy Program, School of Health and Social Work, Fresno 93740 (Darlene L. Stewart).

CALIFORNIA STATE UNIVERSITY, LONG BEACH (1A). Physical Therapy Dept, School of Allied Arts and Sciences, 1250 Bellflower Blvd, Long Beach 90840 (Ray J. Morris).

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE (1A, 1B). Physical Therapy Program, Health Science Dept, Eng 220, 18111 Nordhoff St, Northridge 91330 (Mary Ellen Etherington, EdD).

CHILDREN'S HOSPITAL OF LOS ANGELES/CHAPMAN COLLEGE (5). School of Physical Therapy, Box 54700, Los Angeles 90027 (Judith S. Canfield, EdD).

LOMA LINDA UNIVERSITY (1A, 1B). Dept of Physical Therapy, School of Allied Health Professions, Loma Linda 92350 (Edd J. Ashley, EdD).

MOUNT ST. MARY'S COLLEGE (1A, 1B, 4). Dept of Physical Therapy, 12001 Chalon Rd, Los Angeles 90049 (Patricia Rae Evans).

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO (1A, 1B, 2). Curriculum in Physical Therapy, School of Medicine, Rm U-512, San Francisco 94143.

UNIVERSITY OF SOUTHERN CALIFORNIA (5). Dept of Physical Therapy, Rancho Los Amigos Center, 12933 Erickson Ave, Downey 90242.

COLORADO

UNIVERSITY OF COLORADO (1A, 1B). Health Science Center, Curriculum in Physical Therapy, 4200 E Ninth Ave, Box C244, Denver 80262 (Elizabeth Barnett).

CONNECTICUT

QUINNIPIAC COLLEGE (1A). Dept of Physical Therapy, School of Allied Health and Natural Sciences, 515 Sherman Ave, Hamden 06518 (Harold Potts, Edward P. Tantorski).

UNIVERSITY OF CONNECTICUT (1A). Program in Physical Therapy, School of Allied Health Professions, U-101, Storrs 06268 (Joseph Smey, EdD).

DELAWARE

UNIVERSITY OF DELAWARE (1A). Physical Therapy Program, School of Life and Health Sciences, 049 McKinly Laboratory, Newark 19716 (Paul Mettler, EdD).

DISTRICT OF COLUMBIA

HOWARD UNIVERSITY (1A). Dept of Physical Therapy, College of Allied Health Sciences, 6th and Bryant Sts NW, Washington, DC 20059 (Carol C. Burnett).

FLORIDA

FLORIDA A & M UNIVERSITY (1A). Div of Physical Therapy, School of Allied Health Sciences, Tallahassee 32307 (Ray Patterson, EdD).

FLORIDA INTERNATIONAL UNIVERSITY (1A, 1B). Dept of Physical Therapy, School of Health Sciences, Miami 33199 (Awilda R. Haskins).

UNIVERSITY OF FLORIDA (1A, 1B). Dept of Physical Therapy, College of Health Related Professions, PO Box J-154, JHMHC, Gainesville 32610 (Martha A. Clendenin, PhD).

UNIVERSITY OF MIAMI (1A, 5). Program in Physical Therapy, School of Education and Allied Health Professions, 5801 Red Rd, Coral Gables 33143.

GEORGIA

EMORY UNIVERSITY (5). Div of Physical Therapy, 1441 Clifton Rd SE, Atlanta 30322 (Pamela Catlin, EdD).

GEORGIA STATE UNIVERSITY (1A). Dept of Physical Therapy, School of Allied Health Sciences, University Plaza, Atlanta 30303 (Pearl Petterson, PhD).

MEDICAL COLLEGE OF GEORGIA (1A, 1B). Dept of Physical Therapy, School of Allied Health Sciences, Augusta 30912 (Jan Perry).

ILLINOIS

NORTHERN ILLINOIS UNIVERSITY (1A, 1B). Physical Therapy Program, School of Allied Health Professions, DeKalb 60115 (Judith Anderson).

OKLAHOMA

THE UNIVERSITY OF OKLAHOMA (1A). Dept of Physical Therapy, College of Allied Health, Health Science Center, PO 26901, Oklahoma City 73190 (Martha J. Ferretti).

OREGON

PACIFIC UNIVERSITY (5). Dept of Physical Therapy, 2043 College Way, Forest Grove 97116 (Daiva Banaitis, PhD).

PENNSYLVANIA

BEAVER COLLEGE (1A, 5). Dept of Physical Therapy, Glenside 19038 (Jan S. Tecklin).

HAHNEMANN UNIVERSITY (5). Program in Physical Therapy, School of Allied Health Professions MS 502, 201 N 15th St, Philadelphia 19104 (Risa Granick).

PHILADELPHIA COLLEGE OF PHARMACY AND SCIENCE (5). Physical Therapy Program, 43rd St and Kingsessing Mall, Philadelphia 19104 (Kevin A. Cody, PhD).

TEMPLE UNIVERSITY (1A, 1B). Dept of Physical Therapy, College of Allied Health Professions, 3307 N Broad St, Philadelphia 19140 (Christopher E. Bork, PhD).

THOMAS JEFFERSON UNIVERSITY (1A). Dept of Physical Therapy, Rm 830, 103 S Ninth St, Philadelphia 19107 (Jeffrey Rothman, EdD).

UNIVERSITY OF PITTSBURGH (1A, 1B). Program in Physical Therapy, 101 Pennsylvania Hall, Pittsburgh, 15261 (Rosemary Scully, EdD).

UNIVERSITY OF SCRANTON (1A). Dept of Physical Therapy, 5 Jefferson Hall, Scranton 18510 (James Simon, EdD).

SOUTH CAROLINA

MEDICAL UNIVERSITY OF SOUTH CAROLINA (1A, 1B). Physical Therapy Program, 171 Ashley Ave, Charleston 29425 (James R. Morrow, EdD).

TENNESSEE

THE UNIVERSITY OF TENNESSEE (1A, 1B). Program in Physical Therapy, Dept of Rehabilitation Sciences, 800 Madison Ave, Memphis 38163 (Barbara H. Connolly, EdD).

TEXAS

SOUTHWEST TEXAS STATE UNIVERSITY (1A, 1B). Physical Therapy Program, Health Science Center, San Marcos 78666 (Barbara Sanders).

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER (1A, 1B). Dept of Physical Therapy, School of Allied Health, Lubbock 79430 (H. H. Merrifield, PhD).

TEXAS WOMAN'S UNIVERSITY (1A, 5). School of Physical Therapy, Box 22487, TWU Station, Denton 76204 (Ann Walker).

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT DALLAS (1A, 1B). Dept of Physical Therapy, School of Allied Health Sciences, 5323 Harry Hines Blvd, Dallas 75235 (Barney F. LeVeau, PhD).

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO (1A, 1B). Physical Therapy Program, 7703 Floyd Curl Dr, San Antonio 78284 (Pamela E. Stanton, EdD).

UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON (1A, 1B). Dept of Physical Therapy, School of Allied Health Sciences, Galveston 77550 (Betty R. Landen, PhD).

UTAH

UNIVERSITY OF UTAH (1A, 1B). Div of Physical Therapy, College of Health, Annex Wing B, Rm 1130, Salt Lake City 84112 (Terry L. Sanford).

VERMONT

UNIVERSITY OF VERMONT (1A, 1B). Dept of Physical Therapy, School of Allied Health Sciences, 305 Rowell, Burlington 05401 (Samuel B. Feitelberg).

VIRGINIA

OLD DOMINION UNIVERSITY (1A, 1B). Program in Physical Therapy, Dept of Community Health Professions, Education Bldg, Norfolk 23508-8544 (John L. Echternach, EdD).

VIRGINIA COMMONWEALTH UNIVERSITY (1A). Dept of Physical Therapy, Medical College of Virginia, Box 224, Richmond 23298.

WASHINGTON

EASTERN WASHINGTON UNIVERSITY (1A). Div of Health Sciences, Cheney 99004 (Donna El-Din, PhD).

UNIVERSITY OF PUGET SOUND (1A, 1B). School of Physical Therapy, 1500 N Warner, Tacoma 98416 (Lynette Chandler, PhD).

THE UNIVERSITY OF WASHINGTON (1A, 1B). Div of Physical Therapy, Dept of Rehabilitation Medicine RJ-30, Seattle 98195 (Jo Ann McMillan).

WEST VIRGINIA

WEST VIRGINIA UNIVERSITY MEDICAL CENTER (1A). Div of Physical Therapy, School of Medicine Medical Center, PO Box 6302, Morgantown 26506-6302 (Sandy L. Burkart, PhD).

WISCONSIN

MARQUETTE UNIVERSITY (1A). Program in Physical Therapy, Walter Schroeder Complex, Milwaukee 53233 (Richard H. Jensen, PhD).

UNIVERSITY OF WISCONSIN—LA CROSSE (1A, 1B). Dept of Physical Therapy, 243 Cowley Hall, La Crosse 54601 (Mark J. Rowinski, PhD).

UNIVERSITY OF WISCONSIN—MADISON (1A, 1B). Physical Therapy Program, Medical Science Center, 1300 University Ave, Madison 53706 (Susan Harris, PhD).

US ARMY MEDICAL DEPARTMENT

US ARMY MEDICAL DEPARTMENT (5). Program in Physical Therapy, Medicine and Surgery Div, Academy of Health Sciences, US Army—Baylor University, Ft. Sam Houston, TX 78234 (LTC David G. Greathouse, AMSC, PhD).

CANADA

McGILL UNIVERSITY (1A). Physical Therapy Program, 3654 Drummond St, Montreal, Quebec H3G 1Y5 (Sharon Wood-Dauphinee, PhD).

PUERTO RICO

UNIVERSITY OF PUERTO RICO (1A). Dept of Physical and Occupational Therapy, College of Health Related Professions, Medical Sciences Campus, GPO Box 5067, San Juan 00936 (Carmen L. Colon).

Educational Programs Leading to Postgraduate Degrees for Physical Therapists

The following institutions are accredited by the appropriate state or regional accrediting associations. Programs of graduate study are developed to meet needs and interests of students. The listing of these institutions, therefore, does not connote approval or accreditation of the programs of study by the American Physical Therapy Association. The programs listed provide advanced educational opportunities for physical therapists. The degrees that are offered are not necessarily in physical therapy. Information about the programs and the type of degree awarded may be obtained from the program directors.

Key
(1) Master's degree program.
(2) Doctoral degree program.
(3) Nondegree program.

ALABAMA

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM (1). Post-professional Master of Science. Div of Physical Therapy, Birmingham 35294 (Marilyn R. Gossman, PhD).

CALIFORNIA

UNIVERSITY OF SOUTHERN CALIFORNIA (1, 2). Dept of Physical Therapy, Rancho Los Amigos Center, 12933 Erickson Ave, Downey 90242 (Helen J. Hislop, PhD).

FLORIDA

UNIVERSITY OF FLORIDA (1). Dept of Physical Therapy, College of Health Related Professions, PO Box J-154, JHMHC, Gainesville 32610 (Martha A. Ciendenin, PhD).

GEORGIA

EMORY UNIVERSITY (1). Div of Physical Therapy, Dept of Community Health, Atlanta 30322 (Pamela A. Catlin, EdD).

GEORGIA STATE UNIVERSITY (1). Dept of Physical Therapy, College of Allied Health Sciences, University Plaza, Atlanta 30303 (Marylou R. Barnes, EdD).

MEDICAL COLLEGE OF GEORGIA (1). Dept of Physical Therapy, Augusta 30912 (Cathy Kushman).

KENTUCKY

JEFFERSON COMMUNITY COLLEGE. Physical Therapist Assistant Program. Div of Allied Health, PO Box 1036, Louisville 40201 (Patricia Jo Metten).

SOMERSET COMMUNITY COLLEGE. Physical Therapist Assistant Program, 808 Monticello Rd, Somerset 42501 (Ralph M. Crabtree).

MARYLAND

COMMUNITY COLLEGE OF BALTIMORE. Physical Therapist Assistant Program, 2901 Liberty Heights Ave, Baltimore 21215 (Margaret Henry).

MASSACHUSETTS

BECKER JUNIOR COLLEGE. Physical Therapist Assistant Program, Health and Social Services Dept, 61 Sever St, Worchester 01609 (Lydia Deitrick).

LASELL JUNIOR COLLEGE. Physical Therapist Assistant Program, Newton 02166 (Nancy Cardinali).

NEWBURY COLLEGE. Dept of Physical Therapy, 129 Fisher Ave, Brookline 02146.

NORTH SHORE COMMUNITY COLLEGE, Physical Therapist Assistant Program, 3 Essex St, Beverly 01915 (Judith A. James).

SPRINGFIELD TECHNICAL COMMUNITY COLLEGE. Physical Therapist Assistant Program, Bldg 20, One Armory Square, Springfield 01105 (Elizabeth Farquhar Burke).

MICHIGAN

DELTA COLLEGE. Physical Therapist Assistant Program, F-56 Allied Health Bldg, University Center 48710 (Kathleen M. Toonan).

KELLOGG COMMUNITY COLLEGE. Physical Therapist Assistant Program, 450 North Ave, Battle Creek 49016 (Deborah Miller).

MACOMB COMMUNITY COLLEGE. Physical Therapist Assistant Program, 44575 Garfield Rd, Mt. Clemens 48044-3179 (Faye M. Cobb).

MINNESOTA

ST. MARY'S CAMPUS OF THE COLLEGE OF ST. CATHERINE. Physical Therapist Assistant Program, 2500 S Sixth St, Minneapolis 55454 (Alice Mangen Engelhardt).

MISSOURI

PENN VALLEY COMMUNITY COLLEGE. Physical Therapist Assistant Program, 3201 SW Trafficway, Kansas City 64111 (Karen Wingert).

ST. LOUIS COMMUNITY COLLEGE AT MERAMEC. Physical Therapist Assistant Program, 11333 Big Bend Blvd, St. Louis 63122 (Dorothy J. Shelton).

NEW HAMPSHIRE

NEW HAMPSHIRE VOCATIONAL-TECHNICAL COLLEGE. Physical Therapist Assistant Program, Hanover St Extension, Claremont 03743 (Garrett Hull).

NEW JERSEY

ATLANTIC COMMUNITY COLLEGE. Physical Therapist Assistant Program, Mays Landing 08330 (Jodi G. Handler).

ESSEX COMMUNITY COLLEGE. Physical Therapist Assistant Program, 303 University Ave, Newark 07102 (Stanley Mendelson).

FAIRLEIGH DICKINSON UNIVERSITY. Physical Therapist Assistant Program, 285 Madison Ave, Madison 07940 (Virginia Bertholf).

UNION COUNTY COLLEGE. Physical Therapist Assistant Program, 1033 Springfield Ave, Cranford 07016 (Ellen Price).

NEW YORK

INSTITUTE OF REHABILITATION MEDICINE. Physical Therapist Assistant Program, New York University Medical Center, 400 E 34th St, New York 10016 (Catherine Van Olden).

LAGUARDIA COMMUNITY COLLEGE. Physical Therapist Assistant Program, 31-10 Thomas Ave, Long Island City 11101 (C. Vicki Gold).

MARIA COLLEGE. Physical Therapist Assistant Program, 700 New Scotland Ave, Albany 12208-1798 (Linda Scheuer).

NASSAU COMMUNITY COLLEGE. Physical Therapist Assistant Program, Garden City 11530 (Laura Gilkes).

ORANGE COUNTY COMMUNITY COLLEGE. Physical Therapist Assistant Program, 115 South St, Middletown 10940 (Roberta Bernstein).

SUFFOLK COUNTY COMMUNITY COLLEGE. Physical Therapist Assistant Program, Dept of Health Careers, 533 College Rd, Selden 11784 (Marjorie Sherwin).

NORTH CAROLINA

CENTRAL PIEDMONT COMMUNITY COLLEGE. Physical Therapist Assistant Program, PO Box 35009, Charlotte 28235 (Sally Whitten).

FAYETTEVILLE TECHNICAL INSTITUTE. Physical Therapist Assistant Program, PO Box 35236, Fayetteville 28303 (Elaine Eckel).

OHIO

CENTRAL OHIO TECHNICAL COLLEGE. Physical Therapist Assistant Program, Div of Health Technologies, University Dr, Newark 43055 (Amy Heilmann).

CUYAHOGA COMMUNITY COLLEGE. Physical Therapist Assistant Program, Metropolitan Campus, 2900 Community College Ave, Cleveland 44115 (Toby Sternheimer).

SINCLAIR COMMUNITY COLLEGE. Physical Therapist Assistant Program, 444 W Third St, Dayton 45402 (Mattie Kimbro).

STARK TECHNICAL COLLEGE. Physical Therapist Assistant Program, Allied Health Technologies, 6200 Frank Ave NW, Canton 44720 (Patricia Dunlevy).

UNIVERSITY OF CINCINNATI. Physical Therapist Assistant Program, L101 University College, ML #168, Cincinnati 45221-0168 (Sylvia A. Pacholder).

OKLAHOMA

OKLAHOMA CITY COMMUNITY COLLEGE. Physical Therapist Assistant Program, 7777 S May Ave, Oklahoma City 73159 (Rene Ann Transue).

TULSA JUNIOR COLLEGE. Physical Therapist Assistant Program, 909 S Boston Ave, Tulsa 74119 (Mary Lee Eck).

OREGON

MOUNT HOOD COMMUNITY COLLEGE. Physical Therapist Assistant Program, Dept of Physical Therapy, 26000 SE Stark St, Gresham 97030 (Lynn Lippert).

PENNSYLVANIA

ALVERNIA COLLEGE. Physical Therapist Assistant Program, Reading 19607 (Louise Grim).

HARCUM JUNIOR COLLEGE. Physical Therapist Assistant Program, Bryn Mawr 19010 (Nuala Carpenter).

LEHIGH COUNTY COMMUNITY COLLEGE. Physical Therapist Assistant Program, 2370 Main St, Schnecksville 18078 (Wayne Kirker).

THE PENNSYLVANIA STATE UNIVERSITY, HAZLETON. Physical Therapist Assistant Program, Box 704-A, Hazleton 18201 (John P. Sanko).

SOUTH CAROLINA

GREENVILLE TECHNICAL COLLEGE. Physical Therapist Assistant Program, PO Box 5616, Station B, Greenville 29606-5616 (Linda K. Eargle).

TENNESSEE

CHATTANOOGA STATE TECHNICAL COMMUNITY COLLEGE. Physical Therapist Assistant Program, Div of Life and Health Sciences, 4501 Amnicola Hwy, Chattanooga 37406 (Laura Warren).

SHELBY STATE COMMUNITY COLLEGE. Physical Therapist Assistant Program, Div of Allied Health, PO Box 40568, Memphis 38174-0568 (Leo Betzelberger).

VOLUNTEER STATE COMMUNITY COLLEGE. Physical Therapist Assistant Program, P-205, Nashville Pike, Gallatin 37066 (Joe DiVincenzo).

TEXAS

AMARILLO COLLEGE. Physical Therapist Assistant Program, PO Box 447, Amarillo 79178 (Ed Hankard).

AUSTIN COMMUNITY COLLEGE. Physical Therapist Assistant Program, Riverside Campus, 5712 E Riverside, Austin 78741 (Beverly Jean Mashburn).

HOUSTON COMMUNITY COLLEGE. Physical Therapist Assistant Program, 3100 Shenandoah, Houston 77021 (Georgianna Wilson).

McLENNAN COMMUNITY COLLEGE. Physical Therapist Assistant Program, 1400 College Dr, Waco 76708 (Robert Lozano).

PAN AMERICAN UNIVERSITY. Physical Therapist Assistant Program, Div of Health Related Professions, 1201 W University Dr, Edinburg 78539.

ST. PHILIP'S COLLEGE. Physical Therapist Assistant Program, 2111 Nevada St, San Antonio 78203 (Emily Johnson).

TARRANT COUNTY JUNIOR COLLEGE. Physical Therapist Assistant Program, 828 Harwood Rd, Northeast Campus, Hurst 76054 (Mary Jane Castellow).

VIRGINIA

NORTHERN VIRGINIA COMMUNITY COLLEGE. Physical Therapist Assistant Program, 8333 Little River Tpk, Annandale 22003 (Janet Eldridge).

TIDEWATER COMMUNITY COLLEGE. Physical Therapist Assistant Program, 1700 College Crescent, Virginia Beach 23456 (Pamela Bayliss).

WASHINGTON

GREEN RIVER COMMUNITY COLLEGE. Physical Therapist Assistant Program, 12401 SE 320th St, Auburn 98002 (Susan O'Malley).

WISCONSIN

MILWAUKEE AREA TECHNICAL COLLEGE. Physical Therapist Assistant Program, Health Occupations Div, 1015 N Sixth St, Milwaukee 53203 (Donald J. Gavinski).

US AIR FORCE MEDICAL DEPARTMENT

COMMUNITY COLLEGE OF THE AIR FORCE. Physical Therapist Assistant Program, School of Health Care Sciences, MSDB Stop 114, Sheppard Air Force Base, TX 76311-5465 (Maj Rhonda L. Edwards).

PUERTO RICO

HUMACAO UNIVERSITY COLLEGE. Physical Therapy and Occupational Therapy Programs, CUH Station, Humacao 00661 (Maria G. Prospero).

PONCE TECHNOLOGICAL UNIVERSITY COLLEGE. Univ of Puerto Rico, Physical Therapist Assistant Program, PO Box 7186, Ponce 00732 (Reinaldo R. Deliz-Borges).

APPENDIX H

The American Occupational Therapy Association, Inc.

DIRECTORY OF EDUCATIONAL PROGRAMS IN OCCUPATIONAL THERAPY

November 1986

The Council on Postsecondary Accreditation and the U.S. Department of Education require that the list of accredited educational programs for the occupational therapist be published annually. In addition, the American Occupational Therapy Association publishes the list of approved educational programs for the occupational therapy assistant. These lists follow.

Professional Programs 1986–1987

The following *entry level* programs are accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the American Occupational Therapy Association. On-site evaluations for program accreditation are conducted at 5-year intervals for initial accreditation and 7-year intervals for reaccreditation. The dates on this list indicate the academic year the next evaluation is anticipated. For specific information, contact the program directly.

Key:

1 Baccalaureate program
2 Postbaccalaureate certificate program
2A Certificate awarded to students in partial fulfillment of master's degree
3 Professional master's degree program
4 Combined BS/MS degree program
a Public nonprofit
b Private nonprofit

ALABAMA

1, a 90/91
University of Alabama in Birmingham
Regional Technical Institute, Room 114
University Station
Birmingham, AL 35294
Carroline Amari, MA, OTR, Director
Division of Occupational Therapy

1, b 90/91
Tuskegee University
Division of Allied Health
School of Nursing and Allied Health
Tuskegee, AL 36088
Marie L. Moore, MS, OTR, FAOTA, Director
Department of Occupational Therapy

ARKANSAS

1, a 89/90
University of Central Arkansas
PO Box 1161
Conway, AR 72032
Marian Q. Ross, MA, OTR/L, FAOTA, Chair
Department of Occupational Therapy

CALIFORNIA

1, b 89/90
Loma Linda University
School of Allied Health Professions
Loma Linda, CA 92350
Edwinna Marshall, MA, OTR, FAOTA, Chair
Department of Occupational Therapy

1, 2A, a 90/91
San Jose State University
School of Applied Arts and Sciences
One Washington Square
San Jose, CA 95192-0001
Lela A. Llorens, PhD, OTR, FAOTA, Chair
Department of Occupational Therapy
(Priority given to California residents)

1, 2A, 3, b 88/89
University of Southern California
12933 Erickson Avenue, Building 30
Downey, CA 90242
Elizabeth J. Yerxa, EdD, OTR, FAOTA, Chair
Department of Occupational Therapy

COLORADO

1, 3, a 86/87
Colorado State University
100 Humanities Building
Fort Collins, CO 80523
Elnora M. Gilfoyle, DSc, OTR, FAOTA, Head
Department of Occupational Therapy

CONNECTICUT

1, 2*, b 90/91
Quinnipiac College
School of Allied Health and Natural Sciences
Hamden, CT 06518
Muriel S. Schwartz, MS, OTR/L, Chairperson
Department of Occupational Therapy
* Program level pending accreditation

DISTRICT OF COLUMBIA

1, b 86/87
Howard University
College of Allied Health Sciences
6th & Bryant Streets, NW
Washington, DC 20059
Joyce B. Lane, MEd, OTR, FAOTA, Chair
Department of Occupational Therapy

FLORIDA

1, a 86/87
Florida International University
Miami, FL 33199
Susan H. Kaplan, MHS, OTR, Acting Chairperson
Department of Occupational Therapy

1, 3*, a 86/87
University of Florida
Box J164, JHMHC
Gainesville, FL 32610
Kay W. Sieg, MEd, OTR, Chair
Department of Occupational Therapy
*Program level pending accreditation

GEORGIA

1, a 91/92
Medical College of Georgia
School of Allied Health Sciences
Augusta, GA 30912
Nancy Prendergast, EdD, OTR/L, FAOTA, Chair
Department of Occupational Therapy

ILLINOIS

1, a 90/91
Chicago State University
College of Allied Health
95th Street at King Drive
Chicago, IL 60628
Artice W. Harmon, MPH, OTR, Director
Occupational Therapy Program

1, a 91/92
University of Illinois at Chicago
College of Associated Health Professions
Health Sciences Center
1919 West Taylor Street
Chicago, IL 60612
Gary Kielhofner, DPH, OTR, Head
Department of Occupational Therapy

3, b 90/91
Rush University, Rush–Presbyterian–St. Luke's Medical Center
1753 West Congress Parkway
Chicago, IL 60612
Cynthia J. Hughes, MEd, OTR, Director
Department of Occupational Therapy

INDIANA

1, a 88/89
Indiana University School of Medicine
Division of Allied Health Sciences
1140 West Michigan Street
Indianapolis, IN 46223
Celestine Hamant, MS, OTR, FAOTA
Associate Professor and Director
Occupational Therapy

KANSAS

1, a 88/89
University of Kansas
School of Allied Health
4017 Hinch Hall
39th and Rainbow Boulevard
Kansas City, KS 66103
Winnie Dunn, PhD, OTR, FAOTA, Chair
Department of Occupational Therapy

KENTUCKY

1, a 87/88
Eastern Kentucky University
Wallace Building, Room 109
Richmond, KY 40475
Joy Anderson, MA, OTR, FAOTA, Chair
Department of Occupational Therapy

LOUISIANA

1, a 87/88
Louisiana State University Medical Center
School of Allied Health Professions
1900 Gravier Street
New Orleans, LA 70112
M. Suzanne Poulton, MHS, L/OTR, Head
Department of Occupational Therapy
Offered: New Orleans, Shreveport*
*Pending accreditation

1, a 87/88
Northeast Louisiana University
School of Allied Health Sciences
Monroe, LA 71209
Lee Sens, MA, OTR, Director
Occupational Therapy Program

MAINE

1, b 90/91
University of New England
College of Arts and Sciences
Biddeford, ME 04005
Judith G. Kimball, PhD, OTR, FAOTA, Director
Division of Occupational Therapy

MARYLAND

1, a 87/88
Towson State University
Towson, MD 21204
Marie-Louise Blount, AM, OTR, Chair
Occupational Therapy Department

MASSACHUSETTS

1, 3, b 86/87
Boston University, Sargent College of Allied Health Professions
University Road
Boston, MA 02215
Anne Henderson, PhD, OTR, FAOTA, Chair
Department of Occupational Therapy

1, 3, b 89/90
Tufts University–Boston School of Occupational Therapy
Medford, MA 02155
Sharan L. Schwartzberg, EdD, OTR, FAOTA, Chairperson
Department of Occupational Therapy

MICHIGAN

1, a 90/91
Eastern Michigan University
Department of Associated Health Professions
328 King Hall
Ypsilanti, MI 48197
Ruth Ann Hansen, PhD, OTR, FAOTA, Program Director
Occupational Therapy Program

1, 2, a 86/87
Wayne State University
College of Pharmacy and Allied Health Professions
Detroit, MI 48202
Miriam C. Freeling, MA, OTR, FAOTA, Chair
Department of Occupational Therapy

1, 3, a 91/92
Western Michigan University
Kalamazoo, MI 49008
Claire Callan, EdS, OTR, Chair
Department of Occupational Therapy

MINNESOTA

1, a 86/87
University of Minnesota
Health Sciences Center
Box 388, Mayo Building
Minneapolis, MN 55455
Rondell S. Berkeland, MPH, OTR, Program Director
Program in Occupational Therapy

1, 2, b 86/87
College of St. Catherine
2004 Randolph Avenue
St. Paul, MN 55105
Sr. Miriam Joseph Cummings, MA, OTR, FAOTA, Director
Department of Occupational Therapy

MISSOURI

1*, 3**, a 88/89
University of Missouri–Columbia
Health Related Professions
124 Lewis Hall
Columbia, MO 65211
Diana J. Baldwin, MA, OTR, Director
Occupational Therapy Curriculum
* Preference given to Missouri residents
** Admission to this level is closed

1, b 89/90
Washington University
School of Medicine
4567 Scott Avenue
St. Louis, MO 63110
Mary Ann Boyle, PhD, OTR
Elias Michael Director
Program in Occupational Therapy

NEW HAMPSHIRE

1, a 89/90
University of New Hampshire
School of Health Studies
Hewitt Hall
Durham, NH 03824
Barbara Sussenberger, MS, OTR, Chair
Occupational Therapy Department

NEW JERSEY

1, 2, a 88/89
Kean College of New Jersey
Willis 311, Morris Avenue
Union, NJ 07083
Paula Kramer, M/ . OTR, FAOTA,
Chairperson
Occupational Therapy Department

NEW YORK

1, a 91/92
University at Buffalo, State University of New York
515 Stockton Kimball Tower
3435 Main Street
Buffalo, NY 14214
Karen E. Schanzenbacher, MS, OTR
Acting Chair and Assistant Professor
Department of Occupational Therapy

3, b 86/87
Columbia University
College of Physicians and Surgeons
630 West 168th Street
New York, NY 10032
Barbara Neuhaus, EdD, OTR, FAOTA,
Director
Programs in Occupational Therapy

1, b 90/91
Dominican College of Blauvelt
10 Western Highway
Orangeburg, NY 10962
Kenneth Skrivanek, MA, OTR, Coordinator
Occupational Therapy Program

1, 3, b 88/89
New York University
Division of Health
34 Stuyvesant Street, Room 101
New York, NY 10003
Deborah R. Labovitz, PhD, OTR, FAOTA,
Chair
Department of Occupational Therapy

1, a 87/88
State University of New York
Health Science Center at Brooklyn
450 Clarkson Avenue, Box 81
Brooklyn, NY 11203
Patricia Trossman, MA, OTR, Chairman
Occupational Therapy Program

1, b 86/87
Utica College of Syracuse University
Division of Allied Health
Burrstone Road
Utica, NY 13502
Richard C. Wright, MS, OTR, Director
Curriculum in Occupational Therapy

1, a 86/87
York College of the City University of New York
Jamaica, NY 11451
Wimberly Edwards, MS, OTR, FAOTA,
Coordinator
Occupational Therapy Program

NORTH CAROLINA

1, a 89/90
East Carolina University
School of Allied Health and Social Work
Greenville, NC 27834
Margaret Wittman, MS, OTR/L Chair
Department of Occupational Therapy

3, a 92/93
University of North Carolina at Chapel Hill
Medical School, Wing E 222H
Chapel Hill, NC 27514
Cathy Nielson, MPH, OTR/L, Acting
Director
Occupational Therapy Division

NORTH DAKOTA

1, a 89/90
University of North Dakota
Box 8036, University Station
Grand Forks, ND 58202
Sue McIntyre, MS, OTR, Chairperson
Department of Occupational Therapy

OHIO

1, 2, a 86/87
Cleveland State University
Health Sciences Department
College of Arts and Sciences
1983 East 24th Street
Cleveland, OH 44115
Julia Miller, MEd, OTR/L, Director
Occupational Therapy Program

1, 2, a 90/91
Ohio State University
School of Allied Medical Professions
1583 Perry Street
Columbus, OH 43210
H. Kay Grant, PhD, OTR/L, FAOTA,
Director
Occupational Therapy Division

OKLAHOMA

1, a 92/93
University of Oklahoma
Health Sciences Center
College of Allied Health
PO Box 26901
Oklahoma City, OK 73190
Sharon Sanderson Nelson, MPH, OTR,
Chair
Department of Occupational Therapy

OREGON

1, b 90/91
Pacific University
2043 College Way
Forest Grove, OR 97116
Molly McEwen, MHS, OTR, Director
Occupational Therapy Department

PENNSYLVANIA

1, b 88/89
Elizabethtown College
Elizabethtown, PA 17022-0521
Robert K. Bing, EdD, OTR, FAOTA
Professor and Chairman
Department of Occupational Therapy

1, b 91/92
College Misericordia
Division of Allied Health Professions
Dallas, PA 18612
Jack Kasar, MS, OTR/L, Program Director
Occupational Therapy Program

1, b 89/90
University of Pittsburgh
School of Health Related Professions
204 Mineral Industries Building
Pittsburgh, PA 15260
Caroline R. Brayley, MEd, OTR/L, FAOTA,
Director
Program in Occupational Therapy

1, 2A, 3, a, b 86/87
Temple University
College of Allied Health Professions
Health Sciences Campus
3307 North Broad Street
Philadelphia, PA 19140
Elizabeth G. Tiffany, MEd, OTR/L,
FAOTA, Interim Chair
Department of Occupational Therapy

1, 2, b 90/91
Thomas Jefferson University
College of Allied Health Sciences
Edison Building, Room 820
130 South 9th Street
Philadelphia, PA 19107
Ruth Ellen Levine, EdD, OTR, FAOTA
Department of Occupational Therapy

PUERTO RICO

1*, a 92/93
University of Puerto Rico
Medical Sciences Campus
College of Health Related Professions
Physical and Occupational Therapy
Department
GPO Box 5067
San Juan, PR 00936
Elsie Rodriguez de Vergara, ScD(c), OTR,
Director
Occupational Therapy Program
* Does not accept nonresident students

SOUTH CAROLINA

1, a 88/89
Medical University of South Carolina
College of Health Related Professions
171 Ashley Avenue—Room 224
Charleston, SC 29425
Maralynne D. Mitcham, PhD, OTR/L
Associate Professor and Chairman
Occupational Therapy Educational Department

TEXAS

1, a 92/93
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284
Charles H. Christiansen, EdD, OTR, FAOTA
Professor and Director
Occupational Therapy Program

1, a 90/91
University of Texas School of Allied Health Sciences at Galveston
University of Texas Medical Branch at Galveston
Galveston, TX 77550
Donald A. Davidson, MA, OTR
Associate Professor and Chairman
Department of Occupational Therapy

1, a 89/90
Texas Tech University Health Sciences Center
School of Allied Health
Lubbock, TX 79430
Laurence N. Peake, PhD, OTR, FAOTA, Chair
Department of Occupational Therapy

1, 2, 3, a 92/93
Texas Woman's University
Box 23718, TWU Station
Denton, TX 76204
Grace E. Gilkeson, EdD, OTR, FAOTA, Dean
School of Occupational Therapy
Offered: Denton, Dallas, Houston

VIRGINIA

1, 3, a 92/93
Virginia Commonwealth University
Box 8, MCV Station
Richmond, VA 23298
M. Jeanne Madigan, EdD, OTR, FAOTA, Chair
Department of Occupational Therapy

WASHINGTON

1, 2, 3, b 86/87
University of Puget Sound
1500 North Warner
Tacoma, WA 98416
Margo B. Holm, PhD, OTR, Director
School of Occupational Therapy

1, a 87/88
University of Washington
School of Medicine, Department of Rehabilitation Medicine, RJ-30
Seattle, WA 98195
Elizabeth M. Kanny, MA, OTR, Head
Division of Occupational Therapy

WISCONSIN

1, b 87/88
Mount Mary College
2900 North Menomonee River Parkway
Milwaukee, WI 53222
Diana Bartels, M.A., OTR, Acting Chairperson
Occupational Therapy Department

1, a 92/93
University of Wisconsin–Madison
1300 University Avenue
Madison, WI 53706
Rita Hohlstein, MS, OTR, Coordinator
Occupational Therapy Program

1, a 88/89
University of Wisconsin–Milwaukee
School of Allied Health Professions
PO Box 413
Milwaukee, WI 53201
Franklin Stein, PhD, OTR, Director
Occupational Therapy Program

Developing Professional Programs 1986–1987

The following *entry level* programs are in the developing stage and are not yet accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the American Occupational Therapy Association. The dates of the academic year for the initial on-site evaluation of the program appear in the listing. For specific information, contact the program directly.

INDIANA

3, b 86/87
University of Indianapolis
1400 East Hanna Avenue
Indianapolis, IN 46227
Zona R. Weeks, PhD, OTR, FAOTA, Chairperson
Occupational Therapy Program

MASSACHUSETTS

1, a 87/88
Worcester State College
486 Chandler Street
Worcester, MA 01602-2597
Donna M. Joss, EdD, OTR/L, Director
Occupational Therapy Program

NEBRASKA

1, b 86/87
Creighton University
School of Pharmacy and Allied Health Professions
Omaha, NE 68178
Patricia A. Gromak, MA, OTR/L, Acting Chairman
Department of Occupational Therapy

NEW YORK

4*, b 90/91
D'Youville College
One D'Youville Square
320 Porter Avenue
Buffalo, NY 14201-1084
Linda DiJoseph, MS, OTR, FAOTA, Program Director
Occupational Therapy Program
* 5-year program

1, b 88/89
Keuka College
Keuka Park, NY 14478-0098
Shirley Zurchauer, MSW, OTR, FAOTA
Chair, Division of Special Programs
Program in Occupational Therapy

Technical Programs 1986–1987

The following *entry level* programs are approved by the American Occupational Therapy Association. On-site evaluations for program approval are conducted at 5-year intervals for initial approval and 7-year intervals for reapproval. The dates on this list indicate the academic year the next evaluation is anticipated. For specific information, contact the program directly.

Key: 1 Associate degree program
2 Certificate program
a Public nonprofit
b Private nonprofit

ALABAMA

1, a 90/91
University of Alabama in Birmingham
Regional Technical Institute, Room 114
University Station
Birmingham, AL 35294
Carroline Amari, MA, OTR, Director
Division of Occupational Therapy

COLORADO

1, a 90/91
Pueblo Community College
900 West Ormat Avenue
Pueblo, CO 81004
Terry R. Hawkins, MPH, OTR, Director
Occupational Therapy Assistant Program

CONNECTICUT

1, a 91/92
Manchester Community College
PO Box 1046, MS #19
Manchester, CT 06040
Brenda Smaga, MS, OTR/L, Coordinator
Occupational Therapy Assistant Program

FLORIDA

1, a 86/87
Palm Beach Junior College
4200 South Congress Avenue
Lake Worth, FL 33461
Sylvia Meeker, MS, OTR, Director
Occupational Therapy Assistant Program

HAWAII

1, a 92/93
Kapiolani Community College
Allied Health Department
4303 Diamond Head Road
Honolulu, HI 96816
Ann Kadoguchi, OTR, Director
Occupational Therapy Assistant Program

ILLINOIS

1, a 92/93
Chicago City-Wide College/Cook County Hospital
Health Services Institute at Cook County Hospital
1900 West Polk Street
Chicago, IL 60612
Susan Kennedy, MS, OTR/L, Program Director
Occupational Therapy Assistant Program

1*, a 86/87
Illinois Central College
East Peoria, IL 61635
Javan E. Walker, Jr., MA, OTR/L, Director
Occupational Therapy Assistant Program
* Does not accept out-of-state students

1, a 90/91
Thornton Community College
15800 South State Street
South Holland, IL 60473
Carolyn A. Yoss, OTR, Coordinator
Occupational Therapy Assistant Program

INDIANA

1, a 88/89
Indiana University School of Medicine
Division of Allied Health Sciences
Coleman Hall—311
1140 West Michigan Street
Indianapolis, IN 46223
Celestine Hamant, MS, OTR, FAOTA
Associate Professor and Director
Occupational Therapy

IOWA

1, a 89/90
Kirkwood Community College
PO Box 2068
6301 Kirkwood Boulevard
Cedar Rapids, IA 52406
Mary Ellen Dunford, OTR/L, Director
Occupational Therapy Assistant Program

KANSAS

1, 2, a 91/92
Barton County Community College
Great Bend, KS 67530
Judy White, OTR, Director
Occupational Therapy Assistant Program

LOUISIANA

1, a 87/88
Northeast Louisiana University
School of Allied Health Sciences
College of Pharmacy and Health Sciences
Monroe, LA 71209
Lee Sens, MA, OTR, Director
Occupational Therapy Assistant Program

MASSACHUSETTS

1, b 89/90
Becker Junior College
61 Sever Street
Worcester, MA 01609
Edith C. Fenton, MS, OTR/L, Coordinator
Occupational Therapy Assistant Program

1, a 87/88
North Shore Community College
3 Essex Street
Beverly, MA 01915
Sophia K. Fowler, L/OTR, Director
Occupational Therapy Assistant Program

1, 2, a 91/92
Quinsigamond Community College
670 West Boylston Street
Worcester, MA 01606
Elaine Fallon, MS, OTR, Coordinator
Occupational Therapy Assistant Program

MICHIGAN

1, a 92/93
Grand Rapids Junior College
143 Bostwick, NE
Grand Rapids, MI 49503
Alice A. Donahue, MA, OTR, Director
Occupational Therapy Assisting Program

1, a 91/92
Schoolcraft College
1751 Radcliff Street
Garden City, MI 48135-1195
Masline Horton, MS, Edsp, OTR
Professor/Coordinator
Occupational Therapy Assistant Program

1, a 87/88
Wayne County Community College
1001 West Fort Street
Detroit, MI 48226
Doris Y. Witherspoon, MA, OTR, Director
Occupational Therapy Assistant Program

MINNESOTA

1, a 89/90
Anoka Vocational Technical Institute
1355 West Main Street
Anoka, MN 55303
Julie Jepsen Thomas, MHE, OTR, Director
Occupational Therapy Assistant Program

2, a 92/93
Duluth Area Vocational Technical Institute
2101 Trinity Road
Duluth, MN 55811
Julie A. Hziom, OTR, Director
Occupational Therapy Assistant Program

1, b 92/93
St. Mary's Campus of the College of St. Catherine
2500 South Sixth Street
Minneapolis, MN 55454
Louise C. Fawcett, MHS, OTR, Director
Occupational Therapy Assistant Program

MISSOURI

1, a 90/91
Penn Valley Community College
3201 Southwest Trafficway
Kansas City, MO 64111
Kathryn Duvenci, MA, OTR, Director
Occupational Therapy Assistant Program

1, a 89/90
St. Louis Community College at Meramec
11333 Big Bend Boulevard
St. Louis, MO 63122
Carol Niman-Reed, MS, OTR, Director
Occupational Therapy Assistant Program

NEW HAMPSHIRE

1, a 88/89
New Hampshire Vocational-Technical College
Hanover Street Extension
Claremont, NH 03743
Deborah Lord, OTR, Director
Occupational Therapy Assistant Program

NEW JERSEY

1, a 88/89
Atlantic Community College
Allied Health Division
Mays Landing, NJ 08330
Angela J. Busullo, MEd, OTR, Director
Occupational Therapy Assistant Program

1, a 86/87
Union County College
1700 Raritan Road
Scotch Plains, NJ 07076
Carol Keating, MA, OTR, Program Director
Occupational Therapy Assistant Program

NEW YORK

1, a 88/89
Erie Community College
Main Street and Youngs Road
Buffalo, NY 14221
Sally Jo Harris, MS, OTR/L, Director
Occupational Therapy Assistant Program

1, a 86/87
Herkimer County Community College
Herkimer, NY 13350
Brice Kisder, OTR/L, Program Director
Occupational Therapy Assistant Program

1, a 90/91
LaGuardia Community College
31-10 Thomson Avenue
Long Island City, NY 11101
Naomi S. Greenberg, MPH, PhD, OTR, FAOTA, Director
Occupational Therapy Assistant Program

1, b 92/93
Maria College
700 New Scotland Avenue
Albany, NY 12208
Beardean B. Burke, MA, OTR, FAOTA, Coordinator
Occupational Therapy Assistant Program

1, b 87/88
Maria Regina College
Applied Science Division
1024 Court Street
Syracuse, NY 13208
Sr. Thomas Marie Corcoran, MS, OTR, Director
Occupational Therapy Assistant Program

1, a 88/89
Orange County Community College
115 South Street
Middletown, NY 10940
Mary Sands, MSEd, OTR, Chair
Occupational Therapy Assistant Program

1, a 92/93
Rockland Community College
145 College Road
Suffern, NY 10901
Ellen Spergel, MS, OTR, Director
Occupational Therapy Assistant Program

NORTH CAROLINA

1, a 88/89
Caldwell Community College and Technical Institute
1000 Hickory Boulevard
Hudson, NC 28638
Lyndon Lackey, OTR/L, Coordinator
Occupational Therapy Assistant Program

1, a 87/88
Stanly Technical College
Route 4, Box 55
Albemarle, NC 28001
Noel S. Levan, MA, OTR, Program Director
Occupational Therapy Assistant Program

NORTH DAKOTA

1, a 86/87
North Dakota State School of Science
Wahpeton, ND 58075
Sr. Carolita Mauer, MA, OTR/L, Chair
Occupational Therapy Assistant Program

OHIO

1, a 87/88
Cuyahoga Community College
2900 Community College Avenue
Cleveland, OH 44115
Phyllis Zucker, OTR/L, Program Manager
Occupational Therapy Assistant Program

1, b 90/91
Lourdes College
6832 Convent Boulevard
Sylvania, OH 43560
Jean Thomas, MEd, OTR/L, Director
Occupational Therapy Assistant Program

1, a 90/91
Shawnee State University
940 Second Street
Portsmouth, OH 45662
Valerie J. Kramer, OTR, Program Director
Occupational Therapy Assistant Program

1, a 89/90
Stark Technical College
6200 Frank Avenue, NW
Canton, OH 44720
Johannes Kickert, MS, OTR, Director
Occupational Therapy Assistant Program

OKLAHOMA

1, a 87/88
Oklahoma City Community College
7777 South May Avenue
Oklahoma City, OK 73159
Margaret F. Roseboom, OTR, Coordinator
Occupational Therapy Therapeutic Recreation Technician Program

OREGON

1, a 88/89
Mount Hood Community College
26000 SE Stark Street
Gresham, OR 97030
Chris Hencinski, OTR, Coordinator
Occupational Therapy Assistant Program

PENNSYLVANIA

1, a 89/90
Community College of Allegheny County Boyce Campus
595 Beatty Road
Monroeville, PA 15146
Richard L. Allison, MS, OTR/L, Director
Occupational Therapy Assistant Program

1, b 91/92
Harcum Junior College
Bryn Mawr, PA 19010
Jerald P. Stowell, MPH, OTR, Director
Occupational Therapy Assistant Program

1, a 87/88
Lehigh County Community College
2370 Main Street
Schnecksville, PA 18078
Hari Hirama, EdD, OTR, Coordinator
Occupational Therapy Assistant Program

1, b 91/92
Mount Aloysius Junior College
Cresson, PA 16630
Patricia Marvin, MA, OTR/L, Chair
Occupational Therapy Assistant Program

PUERTO RICO

1. a 89/90
Humacao University College
CUH Postal Station
Humacao, PR 00661
Milagros Marrero-Diaz, MPH, OTR, Program Director
Occupational Therapy Program

1. a 91/92
Ponce Technological University College
University of Puerto Rico
PO Box 7186
Ponce, PR 00732
Ana V. Ferran, PhD, OTR, Coordinator
Occupational Therapy Assistant Program

TENNESSEE

1. a 92/93
Nashville State Technical Institute
120 White Bridge Road
Nashville, TN 37209
Anne Drury, MS, OTR, Program Director
Occupational Therapy Assistant Program

TEXAS

2. a 87/88
Academy of Health Sciences, U.S. Army
Medicine & Surgery Division
Fort Sam Houston, TX 78234-6100
LTC Leith Palm, MA, OTR, Chief
Occupational Therapy Branch
(Limited to enlisted personnel in army and air force)

1. a 89/90
Austin Community College
Riverside Campus
5812 E. Riverside Drive
Austin, TX 78741
Martha Sue Carrell, OTR, Department Head
Occupational Therapy Assistant Program

2. a 86/87
Houston Community College
3100 Shenandoah
Houston, TX 77021
Linda Williams, MA, OTR, Coordinator
Occupational Therapy Assistant Program

1. a 92/93
St. Philip's College
2111 Nevada Street
San Antonio, TX 78203
Jana Cragg, OTR, Program Coordinator
Occupational Therapy Assistant Program

WASHINGTON

1. a 89/90
Green River Community College
12401 SE 320th Street
Auburn, WA 98002
Susan Noel Hepler, OTR/L
Acting Program Coordinator
Occupational Therapy Assistant Program

WISCONSIN

1. a 86/87
Fox Valley Technical Institute
1825 North Bluemound Drive
PO Box 2277
Appleton, WI 54913
Thomas H. Kraft, MEd, OTR, Coordinator
Occupational Therapy Assistant Program

1. a 88/89
Madison Area Technical College—TRAUX
Downtown Campus
3550 Anderson Street
Madison, WI 53704-2599
Toni Walski, MS, OTR, Director
Occupational Therapy Assistant Program

1. a 87/88
Milwaukee Area Technical College
1015 North 6th Street
Milwaukee, WI 53203
Suzanne L. Brown, MS, OTR, Coordinator
Occupational Therapy Assistant Program

Developing Technical Programs 1986–1987

The following *entry level* programs are in the developing stage and are not yet approved by the American Occupational Therapy Association. The dates of the academic year for the initial on-site evaluation of the program appear in the listing. For specific information, contact the program directly.

CALIFORNIA

2. a 88/89
North Santa Clara County Regional Occupational Program
1188 Wunderlich Drive
San Jose, CA 95129
Peg Bledsoe, MA, OTR, Acting Director
Occupational Therapy Assistant Program

GEORGIA

1. a 86/87
Medical College of Georgia
School of Allied Health Sciences
Augusta, GA 30912
Nancy Prendergast, EdD, OTR/L, FAOTA, Chair
Department of Occupational Therapy

ILLINOIS

1. a 86/87
Parkland College
2400 West Bradley Avenue
Champaign, IL 61821-1899
Carol Ruch, OTR/L, Coordinator
Occupational Therapy Assistant Program

MARYLAND

1. a 86/87
Catonsville Community College
800 South Rolling Road
Baltimore, MD 21228
Judith Davis, MS, OTR, Coordinator
Occupational Therapy Assistant Program

MASSACHUSETTS

1. b 86/87
Mount Ida College
Junior College Division
777 Dedham Street
Newton Centre, MA 02159
Heather Moulton, OTR/L, Director
Occupational Therapy Assistant Program

MINNESOTA

1. a 87/88
Austin Community College
1600 8th Avenue, N.W.
Austin, MN 55912
Thomas H. Dillon, MA, OTR/L, Program Director
Occupational Therapy Assistant Program

OHIO

1. a 87/88
Cincinnati Technical College
3520 Central Parkway
Cincinnati, OH 45223
Joanne Phillips-Estes, OTR, Program Director
Occupational Therapy Assistant Program

PENNSYLVANIA

1. a 87/88
Williamsport Area Community College
1005 West Third Street
Williamsport, PA 17701-5799
Barbara N. Sims, OTR/L, Program Coordinator
Occupational Therapy Assistant Program

WASHINGTON

1. a 88/89
Yakima Valley Community College
Sixteenth Avenue and Nob Hill Boulevard
PO Box 1647
Yakima, WA 98907
Margaret Bryant, OTR, Acting Program Director
Occupational Therapy Assistant Program

APPENDIX I

AMERICAN PHYSICAL THERAPY ASSOCIATION

DIRECTORY OF STATE PLACEMENT CHAIRMEN

DECEMBER, 1987

Each state chapter develops its procedures for handling placement issues. It is recommended you call the placement chairman in your state to learn the services the chapter offers and the information it will need from you.

ALABAMA

Danny Suiter
617 Byrne Dr
Montgomery AL 36116
205-284-2535

ALASKA

Brian Durham
Providence Hospital
3200 Providence Dr
Anchorage AK 99508
907-564-9115

ARIZONA

Pauline Wampler
Executive Secretary
3602 E Campbell
Phoenix AZ 85018

ARKANSAS

Ameliese Maus
2604 Fair Park
Little Rock AR 72204
501-660-2580

CALIFORNIA

Juana Rogers
Executive Assistant
1107 Ninth St Suite
1050
Sacramento CA 95814
916-446-0069

COLORADO

Rogene Ihlanfeldt
7235 S Newport Way
Englewood CO 80112
303-694-4728

CONNECTICUT

Peter Berry
Executive Officer
CCAPTA
638 Prospect Ave
Hartford CT 06105

DELAWARE

Samuel Cronis
Derby Mill Rd #1
Box 250 A
Dover DE 19901
302-736-4741

DISTRICT OF COLUMBIA

Karen Myer
National Rehabilitation Hospital
102 Irving St, NW
Washington DC 20010
202-877-1510

FLORIDA

Carol Booth
Executive Secretary
PO Box 1308
Tallahassee FL 32302
904-222-1243

GEORGIA

Pearl Pattersen
Executive Officer
2336 Eastway Rd
Decatur GA 30033
404-982-0776

HAWAII

Gwen McKoy
298A Hibiscus
Honolulu HI 96818
808-834-5977

IDAHO

Mark Allen
805 Del Mar Dr
Twin Falls ID 83301
208-324-4301

ILLINOIS

Karen Blacker
Secretary
5801 N Lincoln Ave
Chicago IL 60659
312-271-5735

INDIANA

Ann Clawson
University of
Indianapolis
Physical Therapy
Program
1400 E Hanna Ave
Indianapolis IN 46227

IOWA

Beverly Venturini
Executive Director
1454 30th St
Suite 201
West Des Moines IA
50265
515-223-0165

KANSAS

Patti Aumick
Physical Therapy Dept
St John's Hospital
139 North Penn
Salina KS 67401
913-823-4120

MAINE

James Haskins
56 Pine St
Dover-Foxcroft ME
04426
207-564-3068

MARYLAND

Ellie Want
2nd Vice President
3701 Twin Lakes Court
#809
Baltimoe MD 21207

MASSACHUSETTS

Paula Guarnaccia
Executive Secretary
18 Tremont St
Suite 949
Boston MA 02108
617-523-4285

Joan Drevins
Membership Chairman
61 Betts Rd
Belmont MA 02178
617-735-4328

MICHIGAN

Alan Jeffrey
Executive Director
PO Box 21236
Lansing MI 48909
517-694-8131

MISSISSIPPI

Elliot Fleming
148 Pecon Hill Dr
Clinton MS 39056
601-376-2153

MISSOURI

Christine Smithee
1610 McCausland
St Louis MO 63117
314-821-5300

MONTANA

Barry Olson
6104 Linda Vista
Missoula MT 59803
406-728-4100

NEBRASKA

Karen Cruse
Executive Secretary
PO Box 34730
Omaha NE 68134
402-571-8412

NEVADA

Lynn MacGuire
5440 Oxbow
Las Vegas NV 89119
702-389-0080

NEW HAMPSHIRE

David Robator
Towne Square
12 Parmenter Rd
Londonderry NH 03053
603-434-6582

NEW MEXICO

Barbara Amstad
Division of Physical
Therapy
Health Sciences
Center
Un of New Mexico
Albuquerque NM 87131
505-277-5755

NEW YORK

Doris Matthews
Executive Secretary
200 S Service Rd
Roslyn Heights NY
11577
516-484-0095

NORTH CAROLINA

Rhonda Fowler
Administrative
Secretary
NC Physical Therapy
Assoication
Hartwell Plaza
1027 Highway 70 West
Garner NC 27529

NORTH DAKOTA

James Schill
Editor
Physical Therapy Dept
MCRH
1300 S Columbia Rd
Grand Forks ND 58202
701-780-2315

OHIO

John Starks
114 Dodd Hall
PT Department
472 West 8th Ave
Columbus OH 43210
614-421-3810

OKLAHOMA

Vicki Hill
2421 Big Horn
Edmond OK 73034
405-752-3770

OREGON

Marty McCullough
Executive Secreatary
Oregon Physical
Therapy Association
PO Box 342
Wilsonville OR 97070
503-694-2121

RHODE ISLAND

Kimberly Crealey
5 College Park Court
Warwick RI 02886
401-828-3020

SOUTH CAROLINA

Daniel Schmidt
106 Virginia Circle
Easley SC 29640
803-859-6365

SOUTH DAKOTA

Brett Lynass
HC 55, Box 696
Sturgis SD 57785
605-347-2536

TENNESSEE

Patty Holbrook
4004 Estes Rd
Nashville TN 37215
615-292-7178

UTAH

Joanne Jensen
Executive Officer
620 East 2100 South
Salt Lake City UT
84106
801-466-7508

VERMONT

Laurel Stewart
President
RR 1 Box 249
Hartland VT 05048
603-542-7744

VIRGINIA

VPTA
10806 Trade Rd
Richmond VA 23236
804-379-2099

WASHINGTON

Caryn Porter
Executive Officer
111 W 21st St
Olympia WA 98501
206-352-7290

WEST VIRGINIA

Debby Givens
145 Bradley St
Morgantown WV 26505
304-293-2311

CLINICAL ELECTROPHYSIOLOGY

Susan Michlovitz
Secretary/Program
Chairman
Program in PT
Hahnemann University
Board & Vine St
Philadelphia PA 19102
215-448-4973

RESEARCH

Gary Soderberg
Vice Chairman
Director, Physical
Therapy Education
University of Iowa
Iowa City IA 52242
319-335-9791

SPORTS PHYSICAL THERAPY

Ed Mulligan
3801 West 15th St
Suite 350 A
Plano TX 75075
214-596-1715

STATE LICENSURE & REGULATION

Lynn Kubousek
Grafton State School
PT Department
Grafton ND 58237
701-352-2140

APPENDIX J

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

DIRECTORY OF STATE PLACEMENT CHAIRMEN

OCTOBER, 1987

Each state chapter develops its procedures for handling placement issues. It is recommended you call the placement chairman in your state to learn the services the chapter offers and the information it will need from you.

ALABAMA

Margaret Drake, OTR
University of Alabama
at Birmingham
RTI Room 114
University Station
Birmingham AL 35294

ALASKA

C/O Alaska OT Asso.
3605 Artic Blvd
Suite 1616
Anchorage AK 99503
Attn: Placement Chair
Message: 907-345-0034

ARIZONA

Jim Turnipseed
13615 N 17th Drive
Phoenix AZ 85020
(w) 602-285-3222

ARKANSAS

Pat Bober, OTR
104 Hines Lane
Pearcy AR 71964
(h)(w) 501-767-9489

CALIFORNIA

Kathy Bell
Member Services
OTAC, INC.
1107 - 9th St, Su 1010
Sacramento CA 95814
916-441-OTAC (6822)

COLORADO

Mary Hillary, OTR
120 S Humboldt
Denver CO 80209
(h) 303-722-3222

CONNECTICUT

Carolyn Morrone, OTR
Box 400
Gaylord Hospital
Wallingford CT 06492
(w) 203-269-3344 x331

DELAWARE

Kimberly Pierson
10 Midland Drive
Newark DE 19713
(w) 302-764-3222
(h) 302-737-0892

DISTRICT OF COLUMBIA

Susan Leech
629 Concerto Lane
Silver Spring MD
20901
(w) 301-585-3963
(h) 301-681-8943

FLORIDA

Samantha Schnering
OTR
6401 Hollywood Blvd
Sarasota FL 34242
(w) 813-921-8690
(h) 813-923-6255

GEORGIA

Virginia Allen, OTR
EF 102
Medical College of
Georgia
Augusta GA 30912
(w) 404-721-3641

HAWAII

Virginia Tully, OTR
OTA Hawaii
521 Kawaihae St
Honolulu HI 96825

IDAHO

Jennifer M. Fiero
4450 Stockman Rd
Pocatello ID 83201
(w) 208-234-0777

ILLINOIS

IOTA Offices
c/o CM Services
800 Roosevelt Rd
Bldg C, Suite 20
Glen Ellyn IL 60137
312-858-7850

INDIANA

Celeste Drysdale, OTR
1910 Shenandoah Court
Lafayette IN 47905
(w) 317-447-7300

IOWA

Martha Thein, M.S. OTR/L
712 Heatherwood
Des Moines IA 50265
515-223-8097

KANSAS

Trina Schultz, OTR
G032 "B" Bldg
U of Kansas Med Ctr
39th & Rainbow
Kansas City KS 66103

KENTUCKY

Cindy Coomes Tinnell, OTR
8909 Kaprun Court West
Louisville KY 40220
(h) 502-636-7262

LOUISIANA

Raymond Menard, OTR
4328 Eileen Street
Lake Charles LA 90605

MAINE

Lauren Emery
Plastic & Hand
Surgical Association
244 Western Avenue
S Portland ME 04106
(w) 207-775-3446

MARYLAND

Position Vacant

MASSACHUSETTS

Nancy DiMinico, OTR
56 Green Street
Watertown MA 02172
(h) 617-926-6978

MICHIGAN

Amelia Jones, OTR
12881 Edison
Southgate MI 48195
(w) 313-562-6000 x280

MINNESOTA

Elaine Hartl, COTA
14010 Park Avenue,
South
Burnsville MN 55337
(w) 612-431-7708

MISSOURI

Diana Baldwin, OTR
c/o University of
Missouri-Columbia
124 Lewis Hall
Columbia MO 65211

MISSISSIPPI

Bronwyn A. Keller, OTR
602 Bay Park Drive
Brandon MS 39042
(w) 601-981-2611
(h) 601-992-2273

MONTANA

Dawn R. Braach, OTR
1915 South 12th West
Missoula MT 59801

NEBRASKA

Jelena Wittwer
4117 North 101st St
Omaha NE 68134
(w) 402-572-2275
(h) 402-521-1577

NEVADA

North

Nancy Goll Joslin
PO Box 4297
Incline Villae NV
89450

South

Carol Williams
3994 Trabuco Drive
Las Vegas NV 89110

NEW HAMPSHIRE

Martha Haley, OTR
407 - 6th Street
Dover NH 03820
603-749-4781

NEW JERSEY

Kathy Rousseau, OTR
2 Seymour Terrace
Hackettstown NJ 07840
(h) 201-850-0958
(w) 201-584-8145 x234

NEW MEXICO

Joan Nail, OTR
4720 Sherwood NE
Albuquerque NM 87109
(h) 505-888-0508

NEW YORK

Diane Gayles, OTR
2 Park Row
Box 320
Chatham NY 12037
518-392-9408

NORTH CAROLINA

Management Concept, Inc.
NCOTA Job Placement Service
Hartwell Plaza
1027 Highway 70 West
Garner NC 27529
919-779-5709

NORTH DAKOTA

Ione Olson, OTR
801 Rhinehart Dr, SE
East Grand Gorks MN 56721
(h) 218-773-9223

OHIO

Ardis Bolstad-Methfessel
3147 Morningside Drive
Columbus OH 43202

OKLAHOMA

COTA Programs
Margaret Rosenboom, OTR
Oklahoma City Community College
7777 S May
Oklahoma City OK 73159
405-682-7506

OTR Programs
Toby Hamilton
Oklahoma University Health Science Center
PO Box 26901
Oklahoma City OK 73126
403-271-2411

OREGON

Marty McCullough
Executive Secretary
PO Box 374
Wilsonville OR 97070
503-694-5544

PENNSYLVANIA

Deborah L. Hatch, OTR
3347 Rinker Road
Northampton PA 18067
717-675-2181

PUERTO RICO

Placement Chair
AOTPR
GPO 1558
San Juan PR 00936

RHODE ISLAND

Mary Ellen Greene
93 Prospect St
E Greenwich RI 02818
(w) 401-942-0280
(h) 401-884-6584

SOUTH CAROLINA

Virginia Allen, EdD, OTR/L, FAOTA
625 Pleasant Home Road #58
Augusta GA 80907
(h) 404-868-1416

SOUTH DAKOTA

Deb Whitelaw Gorski, OTR
1008 S 3rd
Sioux Falls SD 57105
(h) 605-335-1213

TENNESSEE

Barbara Wallin, OTR
7756 Devonshire Dr
Knoxville TN 37919
(h) 615-691-8808

TEXAS

TOTA, INC
111 West Anderson Lane
Suite D-104
Austin TX 73752
512-454-TOTA (8682)

UTAH

Karen Lindau, OTR
2442 East Emerson
Salt Lake City UT 84108
(w) 801-581-2733

VERMONT

Linda Kogut, OTR
RD #1, Box 37
Stone Fence Road
Richmond VT 05477
(h) 615-691-8808

VIRGINIA

Gayle Butterfield, OTR
3288 Page Ave, #301
Virginia Beach VA 23451
804-481-9465

WASHINGTON

Washington OT Assoc
PO Box 3263
Midway Station
Kent WA 89032
Attn: Diana M. May
206-242-9862

WEST VIRGINIA

Carol Parrish, OTR/L
2701 Fairlawn Ave
Dunbar WV 25064
(w) 304-766-4866

WISCONSIN

Sally Otvos, OTR
Admin Secretary, WOTA
PO Box 11186
Shorewood WI 53211
414-962-9555

WYOMING

Meg Allen, OTR
Rt 61, Box 15, #4
Lander WY 82520
(w) 307-332-6967
(h) 307-332-5519